BY CHANCE OR BY DESIGN:
THE ORGANIZATIONAL IDENTIFICATION OF ACADEMIC DIRECTORS IN ACADEMIC MEDICAL CENTERS IN THE U.S.

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Krista Hoffmann-Longtin

BY CHANCE OR BY DESIGN: THE ORGANIZATIONAL IDENTIFICATION OF ACADEMIC DIRECTORS IN ACADEMIC MEDICAL CENTERS IN THE U.S.

Academic medical centers (AMCs) are complex, bureaucratic organizations with multiple, interconnected missions and constituencies. What happens in the classroom affects the operating room and lab. Clinical medical school faculty who become clerkship or course directors (called "academic directors" or ADs) often do so because they are gifted educators. They value education, and are responsible for developing faculty, as well as managing curriculum and assessment. These complex roles often lack clear position descriptions and expectations. However, they may face economic pressures to spend more time in clinical duties at the expense of their education responsibilities. This can create conflicts in organizational identification and values, as well as an unclear path to tenure, promotion, and rewards.

This study uses eight in-depth interviews with ADs from four similar institutions to understand how they manage the multiple values and priorities of their roles. Three interrelated concepts were investigated: how faculty become ADs; how they make sense of their roles and values in relationship to those of the institution; and how the structure of AMCs shapes the roles and values of ADs. A thematic analysis revealed connections among faculty socialization, organizational identification, and organizational values.

Findings from this study indicate that ADs are critical to the education mission and can be powerful in shaping the institution. The diverse responsibilities of ADs may create isolation and mean that their paths to promotion are ambiguous or tenuous. Results of the study can be used to shape policies and faculty development efforts for ADs, leading to a clearer reward system and sense of purpose. Understanding ADs experiences more deeply benefits both faculty

and institutions. For faculty, the benefit is more role clarity and individual agency. For AMCs, the benefit is information on how to better meet ADs' needs, thus improving the efficacy of medical education.

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Chapter 1: Introduction

Academic medical centers (AMCs) are complex, bureaucratic organizations with multiple, interconnected missions and constituencies (Brater, 2010). What happens in the classroom affects the operating room and lab. Though numerous studies have been done to review medical education programs and curricula broadly, few studies have explored the career paths of those who lead this charge, and the role the organization plays in shaping those paths. As the responsibilities to treat patients, discover new medical knowledge, and train future physicians become more complex, it will be critical to define and situate the pathways to and roles of medical education leaders within the system, so that institutions can fully benefit from their contributions.

Statement of Problem

Medical education leaders are under intensifying pressure in contemporary AMCs. A number of factors contribute to this challenging environment. First, medical schools in the U.S. have grown dramatically in size and complexity over the last century (Barchi & Lowery, 2000; Bland & Holloway, 1995; Blackburn & Fox, 1976; Halperin, Byyny, Moore, & Morahan, 1995). During that time, values and allocation of time have shifted dramatically. In the past, medical doctor (MD) faculty might have spent the bulk of their time teaching. But, with the advent of large, research-driven AMCs, MD faculty are encouraged to see more patients as a way to generate revenue to support the education and research missions of the institution (Bland & Holloway, 1995). Faculty members in medical schools are required to "move effortlessly from the research laboratory to the bedside and back" (Cooke, Irby, & O'Brien, 2010, p. 13). These layers of responsibility within complex organizations create multiple targets of organizational identification (OID) for medical education leaders. That is to say, for medical education leaders,

these multiple layers of responsibility ask them consistently to negotiate for various values and areas of the organization, depending on which "hat" they are wearing.

Secondly, medical education leaders' roles lack consistency and intentionality. Changes in structure of medical schools and faculty positions have created a level of specialization among medicine faculty. Now, many medical schools have become complex systems of faculty, staff and students in teaching hospitals with multiple divisions, specialties, subspecialties, and research foci, now called AMCs. These organizations rely on academic directors (ADs), academic physicians who specialize in leading the medical education mission, to carry out the important educational tasks of an academic department. Faculty in these roles often hold one of the following titles: vice chair for education, program director, clerkship director, curriculum director, or course director. In addition to being clinically productive, ADs might also be responsible for designing curriculum, evaluating and assessing educational effectiveness, and training colleagues to teach (Schuster & Pangaro, 2010). However, these titles and responsibilities can vary widely from institution to institution and even from department to department. This variability makes it difficult for ADs to identify a cohort of colleagues across specialties and schools.

A third challenge faced by medical education leaders is related to a lack of formal socialization into the role. Medical education leaders are primarily socialized to be medical doctors. Unfortunately, the socialization process for MDs is not thorough or consistent. Adler and Shuval (1978), and later, Hafler and colleagues (2011) argued that the MD socialization process is fraught with competing values and mixed messages. This poor socialization process is confounded for those who take positions in education. Many faculty "fall into" the role, after serving as a chief resident or becoming highly involved on an education committee. They

usually have little formal education training, requiring that they learn on the job.

Fourth, AMCs' values may compete with those in AD positions. Faculty in these roles are required to make sense of and act within the sometimes competing value structures of education, patient care, university service, and research productivity. Because most MDs identify themselves as members of the profession of medicine before becoming a part of their hospital system or educational institution, they may "encounter expectations, values, and ideals in their employing organizations that conflict with those to which they were socialized" (Russo, 1998, p. 73). Rank-and-file MD faculty may deal with this conflict by psychologically distancing themselves from the organization or by more closely identifying with their specialty or profession than their employing organization. But, for medical education leaders, these options are limited. They must work within the complex structure of the institution to complete the important task of educating future physicians.

The lack of intentionality in the creation of the role, combined with the complex structure of AMCs and competing values, has created a class of faculty who experience dissonance in their positions. Though these individuals may value education, their organizations may ask them to see more patients at the expense of their teaching responsibilities (Cooke et al., 2010; Sutkin et al., 2008). These faculty face conflicts in OID and values in their roles (Sutkin et al., 2008), as well as an unclear path to tenure, promotion, and rewards (DeAngelis, 2004). Most of the literature on medical education focuses on how faculty members develop tactical skills in teaching, but has largely ignored the holistic goal of understanding the complex and conflicted role of ADs (Bligh & Brice, 2009; Schuster & Pangaro, 2010; Sutkin et al. 2008).

Purpose of the Study

To address this gap in the literature, the proposed study is designed to generate a grounded theory that explains how ADs manage their multiple targets of OID within AMCs. The proposed theoretical model will take into account the complex interplay between the individual and organizational factors that affect OID. To do this, I will investigate three interrelated concepts: (1) how academic physicians become ADs, (2) how ADs make sense of their roles and values in relationship to those of the institution, and (3) how the organization of AMCs shapes the roles and values of ADs.

The role of the AD has important implications for the future of physician training. Academic directors are often responsible for program accreditation, so they must be well-versed in educational evaluation and curriculum development. Additionally, they are often seen by fellow faculty as the "go-to" education specialists in an academic department, responsible for many aspects of the education mission. As medicine moves toward more collaborative models of care, it will be critical to have a cadre of professionals skilled in and committed to delivering the highest quality education. Academic directors serve at a critical locus in AMCs, providing feedback to medical students and residents, training residents and fellow faculty in pedagogical methods, and sharing important programmatic information with academic deans and department chairs.

Significance

This study of the role and OID of ADs has implications in three areas: individual faculty development, organizational and policy development, and the field of medical education.

Faculty development.

Previous studies (Blackburn & Fox, 1976; Barchi & Lowery, 2000) illustrate that medicine faculty likely encounter a variety of conflicting messages about the nature and values of their work. For ADs, the prevalence of these messages and effect on their work is not well understood. Academic directors face inconsistencies in the culture and structure of their work, ambiguities about the reward structure available to them, and questions related to their professional identities (Bleakley et al., 2011). By linking the bodies of literature on the faculty role in higher education with the literature in medical education and the role of academic physicians, this study provides a new lens to view the implicit individual and organizational factors that shape the OIDs of ADs.

Organizational and policy development.

The second area of implications for this study is within organizational and policy development. Numerous studies (Barchi & Lowery, 2000; Bland & Holloway, 1995; Borges, Navarro, Grover, & Hoban, 2010; DeAngelis, 2004) have addressed the challenges of medicine faculty that focus on education. Even though promotion and tenure policies and appointment tracks have been adapted to meet this growing population of faculty (Bland & Holloway, 1999; Steinert, 2010), these policies do not express the implicit values of AMCs.

As Steinert (2010) contends, "medical education is a social endeavor" (p. 415). Academic directors have identified the importance of a community of scholars in their work (Bleakley et al., 2011; Steinert, 2010). Unfortunately, ADs are situated in AMCs that are not organized to encourage medical education research or collaboration across disciplines. One way to encourage this specifically, within AMCs, is to align the individual goals of faculty with department visions (Bland & Holloway, 1995). A better understanding of ADs will allow this

broad integration of goals and improve performance at the individual and organizational level.

Field of medical education.

The third area of implications for this study is situated in the study of medical education more broadly. Calls for accountability in medical education are stronger than ever (Steinert, 2010). In the past, the identity of "professor" was given to every physician who was asked to "take a student." As faculty roles have become more specialized, fewer physicians teach regularly (DeAngelis, 2004). Medical schools are required to show specific evidence of student learning, a process unfamiliar to most rank-and-file physician educators. As ADs take on this responsibility for the organization at-large, their training as educators comes into question. As such, a better understanding of the process by which academic physicians become ADs can provide a framework for developing a pipeline for future ADs.

Research Questions

The main purpose of this study is to understand the OID of ADs in AMCs. There are few, if any, studies that link OID, the role of ADs, and the structure and organization of AMCs. Therefore, this study will be guided by the following research questions: 1) How do academic physicians become ADs? 2) How do ADs make sense of their multiple targets of OID within AMCs? 3) How does an AMC context shape the roles and values of ADs?

Study Design

I employ a qualitative research methodology for data collection, with a goal of generating a grounded theory of how ADs OIDs are created, maintained, and adjusted (Creswell, 2006; Glaser & Strauss, 1967). By viewing AMCs through the lens of post-structuralism, this study aims to understand the ways in which AMCs shape the role of ADs, and conversely, how ADs negotiate their multiple OIDs within these complex organizations. Here, the goal is to further

explore the top-down and bottom-up processes used to negotiate OID (Ashforth, Harrison, & Corley, 2008; Schuster & Pangaro, 2010; Trowler & Knight, 1999). Recent studies illustrate that OID is influenced by both individual and organizational factors (Ashforth et al., 2008; Kuhn & Nelson, 2002; Larson & Pepper, 2003; Russo, 1998; Scott et al., 1998). By employing a social constructivist epistemology (Charmaz, 2006), I incorporate the voices of ADs, themselves, into the creation of the grounded theory.

To develop this theory, a series of semi-structured interviews were conducted with eight ADs at AMCs. Participants were asked about the pathway they took to get to their current roles; how they learned to do their jobs; how they feel about their roles within their institutions; and what they wished they knew about the role prior to accepting their positions. Data are analyzed as described in Chapter 3, and the findings are aggregated into narratives organized by theme.

Definitions of Terms

Academic Director (AD): This study focuses on the role of academic directors (ADs) in AMCs. ADs have varying titles within AMCs such as vice chair for education, residency director, program director, clerkship director, curriculum director, or course director. Schuster and Pangaro's (2010) definition of the faculty role in AMCs highlights the multiple targets of OID faced by ADs. By attempting to keep a "foot in each world" within organizations (AMCs) that may value each "world" differently, ADs face significant challenges that are unique to this role. Using a pyramid diagram, Schuster and Pangaro (2010) illustrate the levels of responsibility for education among faculty in AMCs.

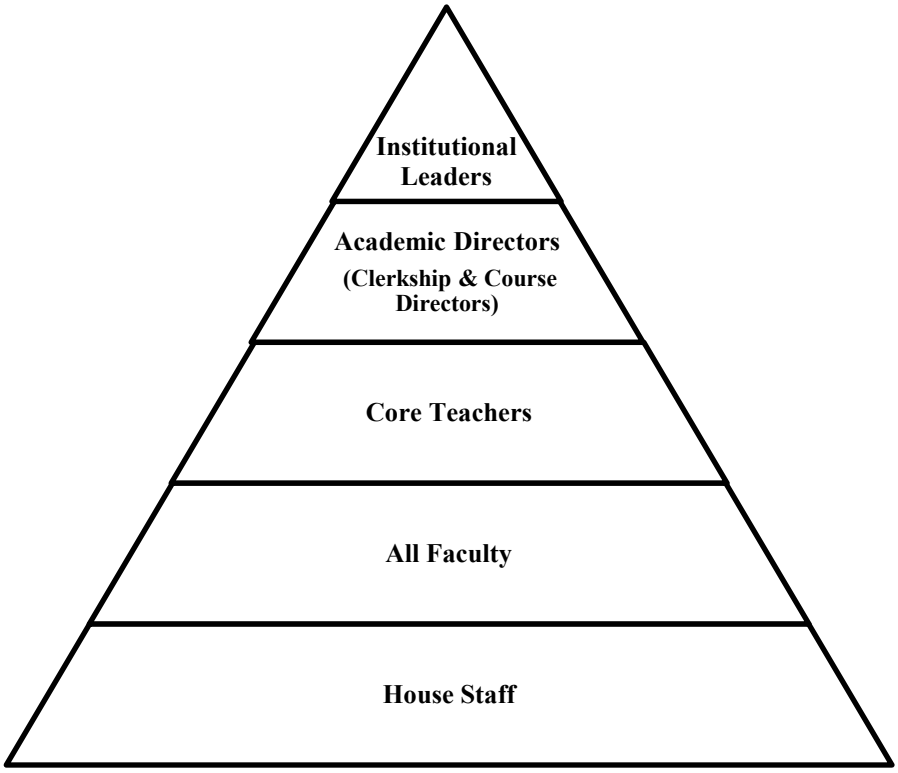

Figure 1.1. Schuster and Pangaro's (2010) model of faculty roles in medical education illustrating the role of Academic Directors as creating a bridge between core teachers of medical education and institutional administrators. In this study, "academic directors" is synonymous with clerkship and course directors. Adapted from *Understanding systems of education: What to expect of, and for, each faculty member,* by L. Pangaro and B. Schuster, 2010, p. 56. In L. Pangaro (Ed.), Leadership Careers in Medical Education (pp. 51–72). Copyright 2010 by the American College of Physicians Press.

In their model, the bottom of the pyramid includes house staff and rank-and-file faculty, who interact with learners in clinical teaching or mentoring, but may not have programmatic responsibilities for education. Institutional leaders are at the top of the pyramid, illustrating that they are small in number, but are ultimately responsible for the educational outcomes of the institution. Academic directors are in between these two groups. By serving as educational consultants to fellow faculty, as well as managing programs, collecting and analyzing educational data, and leading accreditation efforts, they are an important bridge between the faculty at-large and the administration, with respect to educational issues.

Schuster and Pangaro (2010) explain the role as follows:

> [I]n addition to administrative responsibilities for the organization, delivery and assessment of the curriculum, and the evaluation of learners, academic directors usually spend considerable time teaching in multiple settings. They have often accepted their positions after achieving personal success in core teaching arenas, and are often superb teachers gathering energy for the administrative aspects of their positions by continuing their contributions as hands-on educators. Most academic directors also continue to provide clinical care in their specialty or subspecialty and continue scholarly pursuits in an area of personal interest. (p. 56-57)

As Schuster and Pangaro (2010) illustrate, ADs have many responsibilities and roles, as well as many individuals to whom they are accountable. These multiple foci create for a dynamic position within complex organizations.

Academic Medical Center (AMC): According to Cooke and colleagues (2010) AMCs and academic health centers are "medical schools with their university teaching hospitals" (p. 164). According to the Association of American Medical Colleges (AAMC), there are 126 U.S. AMCs. The terms academic medical center (AMC) and academic health center will be used equivalently in this study. However, it is important to note that, "university and teaching hospital values and organizational structures, financial incentives, and regulations sometimes overlap and at other times diverge. Some medical school and teaching hospitals have collaboratively supported and advanced undergraduate and graduate medical education, while others have not" (p. 164).

Faculty Role: Faculty roles in academic medicine have changed dramatically in the past 30 years (Barchi & Lowery, 2000; Bland & Holloway, 1995; Pricewaterhouse Coopers, 2012; Schuster & Pangaro, 2010). Generally, clinical faculty are trained medical doctors who are required to do some combination of teaching, research, and patient care/clinical service. They are often dually employed by a large, research-intensive university/AMC and a practice plan (Cooke et al., 2010). More detail about the evolution of the medical faculty role is addressed in Chapter

2.

Faculty Socialization: According to Austin (2002), "socialization is a process through which an individual becomes part of a group, organization, or community" (p. 96). Tierney and Rhoads (1993) contend that this process is cultural in nature, involving a bi-directional transmission of values, attitudes, and expectations. Scholars agree that the socialization process of faculty in higher education is multi-stage and must be examined within the context of academic discipline (Austin, 2002; Blackburn & Fox, 1976; Hafler et al., 2011; Tierney & Rhoads, 1993).

Bullis and Bach (1989) argue that socialization is an important part of OID. Individuals identify with a group when they feel a sense of belonging with the group and consider themselves members. As such, OID is integrally related to socialization "as a fundamental process of relational development and as a product involving feelings of similarity, belonging, and membership" (Bullis & Bach, 1989, p. 275).

Organizational Identification (OID): Organizational identification (OID) is a sense of belonging and membership to a particular profession or organization (Bullis & Bach, 1989; Jablin, 2001). It is considered by some to be an outcome of both implicit and explicit organizational socialization (Bullis & Bach, 1989). More specifically, scholars of organizations "use *identification* as both a noun and a verb, the former capturing a state of being, a sense of stability, and the latter depicting the process of becoming, denoting variation" (Ashforth et al., 2008, p. 339). An individual's OID can wax and wane over time, and is often shaped by the context of the organization and relationship with others in the group (Bullis & Bach, 1989; Kuhn & Nelson, 2002). Because of its dynamic nature, OID is both a process and a product (Ashforth et al., 2008; Cheney & Tompkins, 1987; Scott, Corman, & Cheney, 1998).

Individuals can feel a sense of identification with multiple sites or targets all at once.

These targets could be inside or outside their organization (Cheney & Tompkins, 1987; Russo, 1998). For example, ADs in AMCs might have the following targets of identification: the profession of medicine, their area of specialty, their hospital, their university, their academic department, or even an undefined group of educators within their institution. The degree of connection an individual feels to these targets may vary based on internal and external factors (Dukerich, Golden, & Shortell, 2002). The factors may be temporal or situational. For example, a pediatrician may feel a close identification with their academic department during a department meeting; however, at a community function, that same physician might introduce him or herself as simply "a doctor," illustrating a closer connection with the field of medicine broadly.

As the field has evolved, scholars have moved away from seeing OID as a top-down or bottom-up process by which the organization transmits identification to the individual or the individuals shapes the organization by enacting their identification. Recent research emphasizes the interactional process between the organization and participant (Ashforth et al., 2008; Kuhn & Nelson, 2002; Larson & Pepper, 2003; Russo, 1998). Ashforth and colleagues' (2008) process model of identification provides important insight into the dynamic nature of OID. In this model, an individual is constantly constructing a narrative of their identity. At any given time, an episode can occur in which the individual is required to enact and interpret (or manage) their identification. The multiple processes by which individuals manage their OIDs will be discussed in depth in Chapter 2.

Values: For the purposes of this study, values are defined as preferences concerning appropriate courses of action or outcomes. An individual's values likely influence their attitudes and behaviors. Values are distinctly connected to OID (Ashforth et al., 2008; Cheney, 1983; Larson & Pepper, 2003; Russo, 1998; Scott et al., 1998). According the Larson and Pepper

(2003), organizations communicate their values to their employees through both direct and indirect methods. Members of the organization, in turn, can adopt or adapt these premises by embodying organizational values in their actions or making decisions with the organization's best interests in mind (Cheney, 1983).

Sensegiving, Sensebreaking, and Sensemaking: As previously explained, this study understands OID as a bidirectional process between the organizational member (the AD) and the OID target (e.g. the AMC, the profession, the group of educators). As Scott and colleagues (1998) explain, "[i]dentification, especially as expressed in symbolic terms, represents the forging, maintenance, and alteration of linkages between persons and groups" (p. 304). The give and take of the OID process described above can be understood in three terms: sensegiving, sensebreaking, and sensemaking (Ashforth et al., 2008). The process by which an organization communicates its values and beliefs to an individual member is deemed *sensegiving* (Ashforth et al., 2008). Sensegiving tactics include using second person pronouns ("we") in publications, uniting against a common enemy, and highlighting outsider praise (DiSanza & Bullis, 1999). Ashforth and colleagues (2008) contend that the sensegiving process can be a powerful force in encouraging identification among organizational members, by "providing the social momentum that encourages continued identity exploration and deepening one's commitment" (p. 343).

Alternatively, *sensebreaking* highlights the gaps between the OID of the individual and that of the organization (Ashforth et al., 2008). By accentuating these gaps, the organization is attempting to encourage the member to strive to acclimate further into the group. For example, a white coat ceremony (where newly minted MD students receive their first white coat) could be considered a sensebreaking activity, in which the student is encouraged to no longer think of themselves as an undergraduate, but instead to think of themselves as a future doctor. It

encourages the students to think, "I am not there now, but it is where I want to be." These sensebreaking activities are often part of the socialization process; however, because ADs lack a unified socialization process, sensebreaking and sensegiving tactics come from multiple directions, creating a sense of confusion in both values and role.

In response to sensegiving and sensebreaking, organizational members sort out these messages in order to determine how they fit into the organization. Ashforth and colleagues (2008) synthesize the literature on this process, called *sensemaking*. While much sensemaking occurs within the socialization process, individuals must continually make sense of who they are in relationship to the organization each time there is a conflict between the two. In the sensemaking process, individuals develop an identity narrative or a story about their role as it relates to the group or organization. According to Ashforth and coauthors (2008), "[t]he process of responding to sensebreaking and sensegiving, enacting a potential identity, and struggling to interpret feedback encourages individuals to tie their emerging identity into their overall identity narrative" (p. 345). In this study, interviews will be conducted to collect identity narratives of ADs and determine the ways in which their OIDs are created, maintained, and adjusted.

Dissertation Overview

In the subsequent chapters, I review relevant literature and provide a methodology for studying the OID of ADs in AMCs. Chapter 2 includes a synthesis of the literature on medical education faculty, as well as a treatment of OID and post-structuralist organizations. Chapter 3 focuses on the philosophical approach to the study, study design, and ethical considerations. In Chapter 4, I provide an overview of the participants and significant narratives to situate their work within the broader contexts of their organizations and academic medicine. Chapter 5 is a presentation of the findings, and in Chapter 6, I offer conclusions and areas for future research.

Chapter 2: Review of Literature

This chapter provides the context for a study of the OID of ADs, situating medical education as a critical task of U.S. AMCs. Relevant work is divided into four sections. 1) First, the review provides a historical overview of the role of medical education in the U.S., providing background and context for the relationship between higher education institutions and academic medicine. A treatment of the structure of AMCs and the rewards systems within provide a framework for illustrating the complexity of the role of faculty in AMCs, specifically ADs. Secondly, the role of faculty within AMCs is compared and contrasted. Then, a more specific overview of the AD role is offered. Third, I frame ADs OID, focusing on how unclear socialization and the complexity of AMCs create for multiple OID targets can confound the sensemaking process. Finally, information on the role of ADs is synthesized with the values and social structure of AMCs to describe institutional factors that may create multiple sites of OID for ADs.

Historical Overview: Early Academic Medicine

During the early 19th century, medical education was dominated by small, private institutions (Cooke et al., 2010; Ludmerer, 1999). The curriculum was not rigorous, and the MD degree was often awarded for simply attending a series of lectures. Most clinical experience was learned in an apprenticeship format (Barchi & Lowery, 2000; Ludmerer, 1999). Then, in 1910, Abraham Flexner conducted a landmark study of all 155 medical schools in North America (Flexner, 1910). The author argued that medical schools should be housed within universities, that high admissions standards were critical, that students should have experiences in laboratories and clinical settings, and that faculty should be highly competent researchers and clinicians (Flexner, 1910).

As a result of Flexner's work, medical schools across the country closely examined their structures and approaches to education (Ludmerer, 1999). During the late 19th century, these institutions began aligning with research universities in response to the public's growing demand for more complex care (Ludmerer, 1999). As Barchi and Lowery (2000) explain, "[t]he core faculty in the new university medical school, with its emphasis on research and teaching, and its intimate association with the broader university, now became the focus for the generation of new knowledge in the biomedical sciences" (p. 900). This shift was fundamental to the nature of faculty work. Medical school faculty participated in clinical practice as a necessary part of training future physicians. However, the primary responsibilities of most academic physicians were scientific thought and inquiry (and their integration into the MD curriculum) (Ludmerer, 1999; Jason & Westberg, 1984).

The roles of faculty in medical schools during the 1950s closely mirrored those of their counterparts in research universities. Faculty appointments and promotion in medicine continued to emphasize efforts in education and research. Much of the revenue for medical schools came from state funds, tuition, and (minimally) from federal or state grant funding (Jason & Westberg, 1982; Ludmerer, 1994). However, between 1965 and1995, medical schools experienced a significant change in structure and funding.

During that time, large numbers of faculty (both physician and non-physician) were hired by medical schools because of an influx of federal funding to increase the number of primary care physicians and advance medical research (Bland & Holloway, 1995; Jason & Westberg, 1982; Ludmerer, 1994). To manage the growth in the educational and clinical enterprises, many universities established AMCs, undergirded by structural and budgetary agreements between medical schools and their associated teaching hospitals. This allowed medical schools to tap into

funding generated by the clinical enterprise of their faculty. In 1960, revenue generated by teaching hospitals accounted for 3% of total AMC budgets nationally. By comparison, in 1995, that number had increased to 44% (Bland & Holloway, 1995).

Once AMC administrators discovered this revenue stream, faculty with clinical expertise were hired in droves. Barchi and Lowery (2000) report that, between 1980 and 1988, the number of full-time clinical faculty at AMCs in the U.S. increased by 50%. Since many AMCs were associated with large research universities, the increase in clinical faculty members created a conflict between medical school faculty and those faculty from traditional undergraduate-focused disciplines (Halperin et al., 1995). These faculty members expressed the concern that the recently-hired academic physicians did not share their traditional university values. More specifically, the university faculty resented "the differentials in salary, the perceived lack of academic productivity, and the lack of 'contact classroom hours' of the medical school clinical faculty" (Halperin et al., 1995, p. 880). Despite this conflict, medical school faculty were often asked to conform to the promotion and tenure requirements and policies of the large, research university. Many of these conflicts and differences in the roles of faculty in AMCs and research universities, at large, still exist today (Pricewaterhouse Coopers, 2012; Schuster & Pangaro, 2010). For ADs, the responsibility of medical education administration is layered upon this already confounding role.

The Structure and Values of AMCs Today

Academic medical centers today still hold the same three key mission areas of education, research, and patient care (Pricewaterhouse Coopers, 2012). For years, the missions have been symbiotic in nature, whereby medical students and residents treat patients while participating in the learning process. Funding for medical education and research has often been generated through faculty physicians and residents seeing patients. But, healthcare reform and the rising

costs of care are threatening the balance of teaching, research and service for AMCs. Additionally, AMCs are "relatively decentralized organizations, sometimes consisting of a swarm of related institutions—a medical college, several hospitals, faculty practice organization(s), and research centers—each with separate leaders and competing goals" (Pricewaterhouse Coopers, 2012, p. 15). The increasingly complex organizational structure, coupled with unprecedented change within the healthcare industry, have put faculty in AMCs (particularly ADs) in a tenuous position, in which they are stuck in between the values systems of multiple organizations and structures (Barchi & Lowery, 2000; Cooke et al., 2010, DeAngelis, 2004; Ovseiko & Buchan, 2012; Swick, 1998). In a recent survey of academic medicine faculty in the UK, Ovseiko and Buchan (2012) found that the health system culture was characterized as "hierarchical," "moderate rational," while the university culture was described as "rational" and "entrepreneurial" (p. 709). These organizational characteristics have created the complex environment in which ADs work.

Defining the Faculty Role in AMCs and Research Universities

In order to provide a clear description of the complexity of the AD role, I first describe the differences between medicine faculty and non-medicine faculty, taking into consideration that these differences hold true for ADs as well. To delineate between the role of faculty members in AMCs and those in outside of medical schools, I use the following terms and definitions. Non-medicine faculty members (those in English, history, engineering, business, or education who serve mostly traditional, undergraduate students) are referred to as "university faculty," while faculty members with MD degrees and appointments in clinical departments of AMCs are called

"medicine faculty."[1] The roles of university faculty and medicine faculty differ in three, interconnected ways.

First, most faculty in AMCs hold appointments in clinical departments, and may be tenure or non-tenure track (Bunton & Mallon, 2007). Regardless of tenure eligibility, these faculty members spend most of their time on patient service, but are often still expected to contribute to the education and research missions of the AMC. On the other hand, most university faculty spend the bulk of their time on teaching and research (Gappa, Austin, & Trice, 2007).

The second primary difference between these faculty roles occurs in the promotion and tenure process. University faculty are more likely to be on the tenure track than medicine faculty (Bunton & Mallon, 2007; Gappa et al., 2007). In both cases, though, the role of tenure has changed dramatically. Criteria for promotion within clinical medicine appointments include excellence in clinical practice and scholarship in areas such as quality improvement or patient safety (Barchi & Lowery, 2000; Pricewaterhouse Coopers, 2012). Promotion for university faculty is based primarily on excellence in disciplinary research and education (Gappa, Austin, & Trice, 2007). While the number of non-tenure track appointments in research universities at large has increased in the past fifty years, this increase has been more dramatic in AMCs (Bunton & Mallon, 2007; Gappa et al., 2007). Further, tenure for medicine faculty in clinical departments is not understood as "job security" as it is for university faculty. Even if a medicine faculty member is on the tenure track, tenure only protects the portion of his or her position that is funded for education or research. A significant portion of medicine faculty salaries are generated by patient service, and

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[1] It is important to note that many AMCs also employ basic science faculty, usually PhD or MD/PhD scientists, whose roles do not include clinical care and more closely resemble university faculty. Because of this congruence, these faculty will not be considered as part of this study.

thus not protected by tenure policy (Halperin et al., 1995; Pricewaterhouse Coopers, 2012).

The third important difference between the roles of university faculty and medicine faculty is associated with positions' funding sources (Bunton & Mallon, 2007). University faculty positions are primarily supported via public funds (state appropriations and financial aid) and tuition dollars. If a university faculty member garners salary support through an extramural grant, this is usually considered scholarship and highly regarded (though often not required) by university promotion and tenure committees (Gappa et al., 2007). However, because medicine faculty salaries are generated primarily through patient service, faculty members are often forced to choose between work that generates revenue (patient care) and work that meets the education mission of the institution (Bunton & Mallon, 2007; Pricewaterhouse Coopers, 2012; Ovseiko & Buchan, 2012). Bland and Holloway (1995) describe how this issue affects medical students: "with their increasing patient-care responsibilities, [medicine faculty] were still able to show up to teach but often had insufficient time to prepare and had no additional time to be available to students" (p. 32). Thus, while AMCs explicitly claim to value education, the institutional structure places a higher value on patient care, often at the expense of education work or a faculty member's free time (Swick, 1998). This can create a conflict of values and targets of OID, especially among ADs, who are directly responsible for the education mission of the institution, but are evaluated more rigorously upon and often paid more for delivering patient care. These three role differences described previously, along with the responsibility of educational administration, constitute the complex faculty role of ADs.

Defining the role of academic directors.

In the century since the Flexner report, funding sources and growth have led to increased specialization for medicine faculty (Cooke et al., 2010; Ludmerer, 1999). In order to manage the

education mission in the large, complex, specialized environments of AMCs, many institutions have created faculty positions that focus on education. These responsibilities are often attached to a traditional medicine faculty role, such that the faculty member is still responsible for seeing patients and doing research. A diversity of titles might accompany the position, including vice chair for education, clerkship director, or curriculum director (Schuster & Pangaro, 2010; Steinert, 2010). For the purposes of this study, these types of educational administration faculty are grouped together into the title of AD (Schuster & Pangaro, 2010).

Today, the role of ADs varies widely across sub-disciplines and institutions (Bleakley et al., 2011; Bligh & Brice, 2009; Ross & Stenfors-Hayes, 2008; Steinert, 2010). Bligh and Brice (2009) enumerate the differences in the role, as well as those who fulfill it: "[An academic director] may have varying responsibilities for research, management, curriculum design, or assessment. Such a huge and heterogeneous workforce resists our efforts to encompass it within a set of standards and competencies" (p. 1161). This role ambiguity can be problematic for socializing faculty who choose this path (Bligh & Brice, 2009; Steinert, 2010). As Bligh and Brice (2009) contend, "medical education seems to be poorly defined as a discipline and a field of practice, and it sometimes appears to be burdened by a weak sense of identity even among those who are active within it" (p. 1161).

A lack of intentionality in the creation of the role and the complex structure of AMCs create a difficult environment for ADs. They struggle with a conflict between their commitment to clinical care and education (Sutkin et al., 2008) and must negotiate an unclear path to tenure, promotion, and rewards (DeAngelis, 2004; Levinson, Bright, & Kroenke, 1998). The lack of clarity in the role of ADs makes it difficult for AMCs to build a pipeline and socialize faculty into these types of positions (Bligh & Brice, 2009; Riesenberg, Little, & Wright, 2009; Steinert, 2010).

Framing Academic Directors' Organizational Identification

Previous studies of those faculty who serve as ADs depict them as role models and deliverers of important curricular content, but fail to fully address the ways in which the ADs, themselves, shape and are shaped by their previous experiences, their current responsibilities, and the organizations in which they work (Bligh & Brice, 2009; Jason & Westberg, 1982; Ross & Stenfors-Hayes, 2008; Steinert, 2010). The goal of this study is to illuminate the factors that shape the OID of ADs. In this study, I employ two frameworks to do so: Scott and colleagues' (1998) structuration model of OID, and Trowler and Knight's (1999) application of post-structuralist organizational theory to faculty socialization. These frameworks allow an examination of how ADs OID is created, maintained, and adjusted.

First, I discuss the process by which academic medicine faculty become ADs. Using the literature of socialization from higher education and medical faculty development, I illustrate that a lack of explicit socialization leads ADs to feel a sense of conflict in their OIDs. Second, building on the dialectical tensions of the role, I explain the OID process and the multiple sites of OID faced by ADs. Lastly, I describe how the structure of AMCs contribute to the tensions of the role.

How Faculty Become ADs: Socialization and OID

According to Austin (2002), "socialization is a process through which an individual becomes part of a group, organization, or community" (p. 96). Scholars in multiple disciplines agree that this process is cultural in nature, involving a bi-directional transmission of values, attitudes, and expectations between the individual and the organization (Ashforth et al., 2008; Bullis & Bach, 1989; Tierney & Rhoads, 1993). One way in which OID is developed is through the organizational socialization process (Ashforth et al., 2008; Bullis & Bach, 1989). During organizational socialization, faculty members learn the rules and values of the organization,

establish identities as members of the organization, and begin to incorporate elements of the organization into their sense of self by enacting their new roles (Ashforth et al., 2008).

Scholars also agree that the socialization process of faculty in higher education is multi-stage and must be examined within the context of academic discipline (Austin, 2002; Blackburn & Fox, 1976; Corcoran & Clark, 1984; Hafler et al., 2011; Tierney & Rhoads, 1993). Specific to academic medicine, Hafler and colleagues (2011) argue that faculty are socialized via a "hidden curriculum" (p. 441). In other words, "becoming a faculty member [in academic medicine] is a process of occupational enculturation that involves a broad range of social practices infused with both formal/explicit and informal/implicit learning dimensions" (Hafler et al., 2011, p. 442). Formal or explicit practices that socialize ADs might include a master's degree program in medical education or structured in-residence courses (Schuster & Pangaro, 2010). Informal or implicit socialization practices might include a colleague sharing information on the funding practices of departments or programs. While the latter clearly has an impact on a medicine faculty member's ability to navigate the system, that information is usually not shared via formal channels of communication (Hafler et al., 2011).

The complexity of this process is confounded for ADs. Academic directors place a high value on the education mission of AMCs, and this may conflict with the values of traditional medicine faculty members and the system overall (Bligh & Brice, 2009; DeAngelis, 2004). Since AMCs often place a higher value on clinical productivity than education, ADs "face inconsistencies in the culture and structure of their workplaces, ambiguities about the nature of the work, and questions related to their professional identities" (Hafler et al., 2011, p. 443). These inconsistencies are rarely managed by AMCs, thus it is the responsibility of ADs to reconcile these conflicts in order to manage the OID process.

The Organizational Identification Process

As previously discussed, OID is a sense of belonging and membership to a particular profession or organization (Bullis & Bach, 1989; Jablin, 2001). It is considered by some to be an outcome of both implicit and explicit organizational socialization (Bullis & Bach, 1989). In their proposed structuration model of OID, Scott and colleagues (1998) make important distinctions between identity and identification that prove useful in the investigation of the role of ADs. According to their model, *identity* is comprised of the values, beliefs, rules and resources used to define a type of individual. On the other hand, *identification* is "the forging, maintenance, and alteration of linkages between person and groups. Often made manifest in social interaction, identification in a structurational sense represents the type of behavior produced by and producing identity" (Scott et al., 1998, p. 304). This research project approaches the OID process in a way consistent with Scott and colleagues' aforementioned model. By conducting individual interviews with ADs, I seek to illuminate how their OIDs are created, maintained, and adjusted.

In many organizations, there are multiple targets with which individuals can identify (Ashforth et al., 2008; Scott et al., 1998). In addition to demographic groups, an employee may identify as being part of a particular department, team, work group, or profession. For example, a physician who is an African-American woman might work in the oncology department of a large AMC, with multiple hospitals. The part of her identity she foregrounds in a story or conversation may change, depending on the context.

In certain situations, these targets of identification may conflict, thus creating a conflict for the individual. By applying this theory, these multiple OID options "serve as both targets toward which employees can direct their identification efforts and sources from which they can draw to understand and interpret meaning" (Larson & Pepper, 2003, p. 530).

In this study of ADs, the multiple (and perhaps competing) options for (or targets of) identification available include the values systems of: the medical profession as a whole, medical specialty, medical education, medical school, hospital system, and university. As such, I treat OID as the process through which ADs either align or distance themselves from the aforementioned targets or sources of identification. This process of connecting and disconnecting can be affected by both temporal and contextual factors.

Management of organizational identification.

Multiple studies (Ashforth et al., 2008; Kuhn & Nelson, 2002; Larson & Pepper, 2003; Russo, 1998) illustrate that identification is not simply passed from the organization to the individual. Rather, employees "are active participants in constructing and reconstructing their identities as they assess the compatibility and completion between relevant identity targets" (Larson & Pepper, 2003, p. 532). Ashforth and colleagues (2008) contend that multiple targets of identification are not always negative. In fact, in reviewing the literature, the authors found that "positive correlations among multiple identifications suggest the possibility of converging and combining processes such that it may be possible to develop parsimonious models of multiple identification" (Ashforth et al., 2008, p. 359).

This fluidity among the sources and identification structure is important when considering the role of ADs. Particular work activities (such as teaching) could evoke one OID, while time spent with a group (at a professional conference) could alter a seemingly stable identification. Scott and colleagues (1998) argue that certain work activities "influence the identities that are appropriated and reproduced in identification. Only in particular situations, defined significantly by activity and activity foci, will a person identify in particular ways" (p. 323). For ADs, whose activities, values, and organizations vary greatly, a more nuanced picture

of OID is important. In fact, by better understanding the identification process, AMCs could provide ADs with the tools necessary to sort through competing targets and sources of identification.

Post-Structuralist Views of Organizations and OID

Traditionally, scholars have studied faculty within the context of functionalist and rationalist models of higher education organizations (Blackburn & Fox, 1976; Tierney & Rhoads, 1993; Trowler & Knight, 1999). Trowler and Knight (1999) argue that this perspective limits the interplay between the individual and the organization. The authors contend that a post-structuralist approach takes into account "the importance of agency, identity, and role of the individual in constructing their social world" (Trowler & Knight, 1999, p. 185) as well as the influence of organizational culture on the socialization process. This same perspective could be applied OID. This approach allows administrators to see OID (and socialization as a subset) as an important part of both individual, professional development, and organizational development. Using this frame, Trowler and Knight (1999) offer five sites at which institutions could attend to faculty socialization in a more intentional way: (a) faculty agency; (b) organizational culture; (c) attention to faculty experience; (d) uncovering tacit knowledge; and (e) the process's complexity. Applying this framework about non-health faculty to aid in the development of a theory of OID of ADs has important implications to both the definition of and experiences of those in the role.

First, Trowler and Knight (1999) argue that faculty "need to be seen as active agents in the process" (p. 185). For ADs, the notion of agency is critical. Faculty who have a greater sense of control over their experiences are likely to be more satisfied (Trowler & Knight, 1999); however, since the fiscal structure of AMCs places a higher value on clinical care than education, ADs may feel a lack of agency in the system. A close exploration of ADs OID helps institutions understand

how to best support faculty in these roles to feel empowered. Second, in AMCs, culture is a complex construct. AMCs can be characterized as having multiple, imbedded cultures under the post-structuralist approach advocated by Trowler and Knight (1999). In AMCs, there are tensions between the organization's structure and its values (DeAngelis, 2004). In the sensemaking process, ADs may challenge or reject the messages they receive from their multiple OID targets, especially if those are not in concordance with their own personal values. Finding ways to reconcile the tension between multiple OIDs could help ADs to navigate their organizations more effectively. Third, Trowler and Knight (1999) advocate for researchers to attend to the lived experience of new faculty members, identifying those norms and values that are transmitted implicitly in everyday interaction. As in the previous example, these implicit messages can have an important impact on how ADs work is situated within their organizations. Fourth, tacit knowledge must be uncovered and made explicit through policy and practice (Trowler & Knight, 1999). Many scholars have illustrated the ways in which the current reward structure in AMCs does not fit well with the work of ADs (Bleakley et al., 2011; Schuster & Pangaro, 2010); so, tacit knowledge is the primary way for ADs to navigate this process. The fifth construct outlined by Trowler and Knight (1999) is that of complexity. While university faculty experience the complexity of "multiple conflicting cultural messages" (p. 190) in higher education institutions, this conflict is heightened for ADs (Bligh & Brice, 2011) because their training does not prepare them to work within the context of an academic values system.

As illustrated, the two perspectives on faculty roles, even combined, do not fully address the complex nature and competing forces shaping the OID of ADs in AMCs. Further, since these studies were conducted in the context of higher education broadly, rather than in AMCs, the values and social structures of these institutions are absent in these perspectives. As Borges and

colleagues (2010) argue, little work exists that explores the interplay between physicians' values, their choice of career path, and how the organization provides support for that choice. Ross and Stenfors-Hayes (2008) agree that the lack of a clear pathway to medical education as a career creates for confusion in role and expectations for faculty who pursue this path. As such, I utilize the aforementioned perspectives to inform a qualitative study of the role and OID of ADs in AMCs (Charmaz, 2006; Ellingson, 2009). This approach provides an interpretive portrayal of the experience of ADs, in order to construct a theory based on AD's implicit meanings of their experiences (Charmaz, 2006).

Chapter 3: Methodology

This study is designed to form a grounded theory that describes the OIDs of ADs in American AMCs. This chapter offers further detail on the philosophical underpinnings, constructivist grounded theory (CGT) and crystallization methodology, and approach to data collection and analysis. I conclude the chapter with a discussion of ethical and trustworthiness considerations for the study.

Philosophical Concepts

Qualitative approach.

Yardley (2000) contends that many researchers adopt qualitative approaches because they recognize that "our knowledge and experience of the world cannot consist of an objective appraisal of some external reality, but is profoundly shaped by our subjective and cultural perspective, and by our conversations and activities" (p. 217). This philosophical orientation is key to this study. Because ADs are situated within complex organizations fulfilling multifaceted roles, their OIDs are influenced by many groups and individuals. Qualitative methods allow the opportunity to parse out some of these experiences, and develop a greater understanding of the broad experience of ADs in AMCs today. The goal of this study is to collect stories as a way to understand a complex process, imbedded in the culture of organizations. As such, qualitative methods are the only way to illuminate the nuanced experiences of faculty in these roles.

More specifically, the reason for the qualitative approach to this study is three-fold. First, in order to discover how ADs' OIDs are created, maintained, and adjusted, I must gain a deep understanding of a complex and individualized process. Qualitative interviews with an emergent protocol play a key role in discovering the personal stories of ADs. Secondly, I seek to develop a theory, rather than test an existing theory. While studies currently exist that address medical

school faculty values (DeAngelis, 2004; Pololi et al., 2009), faculty OID (Humphreys & Brown, 2002; Marchiori & Henkin, 2004; Mills, Bettis, Miller, & Nolan, 2005), and faculty socialization (Blackburn & Fox, 1976; Tierney & Rhodes, 1994), no study exists that addresses the connection between these processes. Creswell (2006) and Charmaz (2005) contend that a qualitative approach is most appropriate when developing a theoretical model. I address a subset of medical school faculty, ADs in AMCs, for which the interplay between complex individual and organizational factors may change the ways in which OID theories can be applied. A qualitative interview approach allows for deep, co-constructed interview data that take into account the unique contexts of the participants. Third, qualitative research methods allow for a purposeful (Creswell, 2006) and theoretical (Charmaz & Belgrave, 2012) sampling strategy. While many ADs have similar roles and responsibilities, their titles can vary across institutions based on the organization's size and structure. By using a purposeful and theoretical sample, participants provide rich, contextually-based cases from which to discern multiple themes and experiences (Creswell, 2006; Kennedy & Lingard, 2006; Van Manen, 1990; Yardley, 2000).

Constructivist grounded theory and dendritic crystallization.

To ensure a strong research design, researchers must choose a paradigm that is congruent with their ontological and epistemological assumptions (Creswell, 2006). For this study, I chose CGT and dendritic crystallization because they provide a participatory approach by which to examine the OID of ADs. Grounded theory is a methodology that seeks to construct hypotheses about the nature of issues important in the lives of the participants (Charmaz, 2005; Glazer & Strauss, 1967). Through a process of inductive data collection, issues of importance to the study participants emerge from the stories they tell about their lived experience. The researcher analyzes the data, constantly comparing it to the field or universe of data collected, until a theory can be

grounded within the participants' experiences (Charmaz, 2005; Glazer & Strauss, 1967). Concurrent data analysis and collection each inform and focus one another as the iterative process proceeds (Charmaz & Belgrave, 2012). The goal of a grounded theory study is to develop "a well-integrated set of concepts that provide a theoretical explanation of a social phenomenon" (Kennedy & Lingard, 2006, p. 103).

Constructivist grounded theory is particularly applicable for this study (Charmaz, 2005). Rooted in relativism and subjectivism, this inquiry approach reshapes the interaction between the researcher and participants (Charmaz, 2005). Rather than focusing on an external reality, CGT suggests that all experiences are, by nature, a reality that is discovered through the interpretation of the data. This approach allows me the opportunity to go beyond the surface in seeking meaning in the data—addressing many of the tacit and implicit issues in the OIDs of ADs. Further, by searching for and questioning the tacit assumptions about their work, I work with the ADs, themselves, to co-produce a theory of their experience (Charmaz, 2005).

Ellingson (2009) contends that CGT combined with other forms of data analysis can "highlight the partiality and culturally specific nature of all knowledge" (p. 56). As this study evolved, the thematic analysis offered one, particular perspective on its findings. The constructivist approach to grounded theory allowed the opportunity for co-construction of the data and theory, focusing on the truths of the participants in the study, their perceptions of academic medicine today, and the efficacy they feel within their roles as ADs. By turning to dendritic crystallization (Ellingson, 2009), I sought to more fully uncover my biases as a researcher and represent the experiences of my participants. By engaging this approach, I sought to develop a holistic reading of the participants' experiences. Certainly, CGT provides a rich account of the experiences of ADs in AMCs. As Ellingson (2009) contends, "[b]eing able to

explain patterns and illustrate them with rich exemplars provide important descriptive and analytical knowledge" (p. 59). However, by blending a more traditional method (such as grounded theory) with the significant narrative analysis, I problematize the structures that might draw the reader to considering one perspective as "right" or "true." With this approach, I hope to "enable us to learn about ourselves, each other and the world through encountering the unique lens of one person's (or a group's) passionate rendering of reality into a moving, artistic expression of meaning" (Ellingson, 2009, p. 62).

The dendritic approach to crystallization includes three traits as its hallmarks: "conscious engagement with an ongoing (re)creative process, responsiveness to the research context(s), and the development of distinct, often asymmetrical branches" (Ellingson, 2009, p. 127). In the case of this study, as it evolved, specific stories emerged that were quite significant (both to the researcher and the participant), but did not neatly fit into the core or thematic categories. However, when taken together, these narratives painted a picture of the experiences of ADs, one that highlighted the relationship between the individual and collective stories of this group. As a cohort, clerkship and course directors represent an understudied but important group of individuals within medical education (Brownfield et al., 2012; Ephgrave, 2010), thus a significant narrative analysis offers a way to give voice to an unorganized and marginalized group in the field.

In this study of ADs, the notion of co-production between the researcher and the participants is a critical part of its impact. Academic directors' own experiences, values, and assumptions play critical roles in how they work within their organizations (Hafler et al., 2011; Marchiori & Henkin, 2005; Pololi et al., 2009). The methodological approaches of this study are grounded in the notion that humans are self-reflexive and reflect on their own management of

experiences. This approach positions verbal understanding from the point of view of the participants as an appropriate source for understanding social phenomena (Lindlof & Taylor, 2010). The verbal sensemaking that occurs during an interview, especially as ADs reflect on their experiences, informs the management of OIDs in multiple contexts (Tompkins & Cheney, 1983). By involving the participants in the creation of the theory, the study has the potential to foreground the experiences of those in the role, providing a sense of voice and privilege where one may not have existed in the past.

Method

Constructivist grounded theory (CGT) (Charmaz, 2006) and dendritic crystallization (Ellingson, 2009) are used to study the OIDs of ADs in AMCs. Constructivist grounded theory offers guidelines that aid the researcher both in data collection and analysis (Charmaz, 2006). Dendritic crystallization can be combined with CGT to allow the researcher to respond to "opportunities, changing relationships, new skills and interests, the needs of participants, and other aspects of their research site or topic" (Ellingson, 2009, p. 127). This section outlines the details of the study, including a description of the sites, participants, sampling technique, data collection methods, and analysis.

Sites.

This study focuses on similarly-sized, public AMCs in the U.S. Using criteria from the AAMC Organizational Characteristics Database (OCD), the NIH funding database, and the AAMC Medical School Admission Requirements (MSAR) database, institutions were chosen based on the following criteria: (1) NIH funding over $120,000,000, (2) a clinical faculty population of 800 or above, and (3) a first-year medical student class size above 100, but below 200. Then, this list was narrowed to include institutions that are geographically distributed

across the U.S. Lastly, the list was narrowed to include institutions whose hospital systems are university-owned, jointly-owned (university and nonprofit partner), and separately-owned (nonprofit partner only). No institutions with for-profit partners were included.

Participants.

The participants in this study were ADs (as defined by Schuster & Pangaro, 2010) employed at a minimum of 80% time at an AMC in the U.S. The faculty members' time was a combination of university and hospital system time. For example, faculty who are employed 50% by the primary affiliate hospital for patient care, and the other 50% for university work, were included. However, those employed by outside hospital systems (such as veteran's hospitals or a hospital that is not considered the university's primary affiliate hospital) were not included.

While participants may have varying academic titles such as "course director," "clerkship director," or "vice chair for education," the study focused on self-identification as way to ensure participants who place value on the role of education within their career trajectory. Faculty members were selected based on their medical education role within a U.S. AMC and their willingness to participate in an interview. All participants had MD degrees, as a way to illuminate the confounding factors associated with clinical productivity requirements. Faculty members focused on graduate medical education (GME) (such as residency directors) were excluded from this study, since faculty in GME roles rely less on the university and more on the hospital system to determine the scope of their work.

Efforts were made to gather a population diverse in medical specialty, as well as demographic characteristics. Once a participant from a particular discipline or demographic group was interviewed, participants with similar experiences were excluded to encourage a

diverse and rich sample. By focusing on a small pool of participants, I sought to attend to the multiple organizational contexts faced by ADs. According to Charmaz (2003), constructivists emphasize "locating their data in context. Thus they may attend to the context of the specific interview, the context of the individual's life, and the contextual aspects of the study and research problem within the setting, society, and historical moment" (p. 314-5).

Sampling.

As a researcher, I cannot exactly know the most significant social and social psychological processes for ADs in AMCs. As such, per Charmaz's (2003) approach, a theoretical sampling technique was employed. Theoretical sampling is "sampling to develop the researcher's theory, not to represent a population" (Charmaz & Belgrave, 2012, p. 358). This technique is particularly useful in a CGT study because it allows the researcher to "return to the field or seek new cases to develop their theoretical categories" (Charmaz & Belgrave, 2012, p. 358). To begin the study, a series of eight interviews were conducted with ADs to explore and examine research participants' experiences and concerns with their roles. This manageable number of initial interviews allowed for axial coding and initial category development. Then, each interview was transcribed and coded for themes as well as significant narratives. The initial theoretical categories were checked with the participants and other ADs in AMCs not involved in the study. The process of member-checking develops a grounded theory that is more "precise, explanatory, and predictive" (Charmaz & Belgrave, 2012, p. 359).

Participants were sought using researcher contacts at each of the institutions, who were members of the Association of American Medical Colleges (AAMC) Group on Educational Affairs (GEA) and Group on Faculty Affairs (GFA). While many participants in AAMC GEA and GFA hold leadership roles within medical education and faculty development, they were

able to direct the request to faculty members who fit the criteria and would be willing to participate.

Data collection.

I used in-depth qualitative interviews to gather data for this study. The interviews were 60 to 90 minutes in length, conducted over a period of four months. A semi-structured interview protocol was employed to conduct the conversations. Interviews were audio and/or video taped with permission of the participants, and were transcribed verbatim. All participants' responses remained confidential, and their names and institutions were masked or replaced with pseudonyms to protect them from any undue risk associated with sharing personal career-related information.

Using a "flexible, emergent technique" (Charmaz, 2003, p. 312), I developed sensitizing concepts and an understanding of how my participants construct meaning in their experiences (Charmaz, 2003; Charmaz & Belgrave, 2012). Simultaneous data collection and analysis, and negative cases were used to refine the sample (Charmaz, 2003). Using these in-depth interviews and iterative coding (Charmaz & Belgrave, 2012), I sought to develop a conceptual analysis of the implicit meanings in ADs experiences within their organizations.

According to Charmaz (2003), "a grounded theory interviewer's questions need to define and explore processes" (p. 314). So, questions centered on the story of how the AD "came to be" in his or her role. The questions were situated within the participants' perceived reality of the AMC. It is important to focus on the truth of the participant in this scenario, rather than the perceived facts the researcher may have, in order to understand how the participants make meaning of their roles and experiences within their institutions. Additionally, this storytelling technique proves useful for Ellingson's (2009) dendritic crystallization approach. These

narratives allowed me to reflect upon the choices made by the participants. These choices helped me, as a researcher, to identify some of the internal and external forces that shaped the identity of my participants. See Appendix A for a complete list of interview questions.

Data analysis.

For data collection and analysis to be true to the grounded theory tradition, interviews and analysis occurred simultaneously. This allowed the protocol to evolve in response to emergent themes (Charmaz, 2003; Charmaz & Belgrave, 2012; Kennedy & Lingard, 2006). This evolution allowed me to maintain the mindset of dendritic crystallization (Ellingson, 2009), "consciously embracing a sense of openness to continual development and evolution" of the project (p. 127). During the interviews, I began coding using sensitizing concepts. Sensitizing concepts (Charmaz, 2003) provide the researcher with an opportunity to consider, at first look, if there are connections to be made among the stories of the participants. After the interviews are transcribed, "the power of grounded theory methods lies in the researcher's piecing together a theoretical narrative that has explanatory and predictive power" (Charmaz, 2003, p. 328). Coding occurred in three stages. First, the transcripts were open coded (Charmaz, 2003). This process involved a line-by-line organization of the data, focusing on both the context and experience of the individual, as well as the actual language used. The codes are constantly compared with other participants in the study, looking for themes across interviews. Secondly, the transcripts were selectively coded. In this process, the researcher goes deeper into the data, with the aim of identifying the emerging theory (Charmaz, 2003). Lastly, I combined the transcript analysis with the written memos from the interviews. The free-written memo provided important context and helped me "to spark fresh ideas, create concepts, and find novel relationships" (Charmaz, 2003, p. 323). By linking raw data with my research memos, I hoped to uncover interpretive content

that might have been unique to this type of study. In addition to the theme structure, narratives identified both by the participants and by the researcher as significant were tagged to be used in the significant narrative analysis (Bruner, 1990; Lawler, 2002; Riessman, 2003).

Thematic analysis.

In order to develop an accurate theoretical description of the OID of ADs, I relied on Van Manen's (1990) perspective on thematic coding. While Van Manen (1990) contends that phenomenology does not "produce empirical or theoretical observations or accounts," his focus on the specific experiences of a study's participants are useful here to focus on the key elements of the experiences of ADs.

Like Charmaz (2003), Van Manen (1990) supports a three-pass method of coding an interview transcript. In the first pass, the researcher takes a "holistic approach" (p. 92), capturing the key meaning of the participant's comments. Secondly, the researcher takes a selective approach, focusing on key phrases or words that might give clues about the meaning of the experience. In the final pass, the researcher focuses on sentences or sentence clusters in order to garner meaning. This approach to coding merges well with CGT and crystallization, because it orients the researcher toward the multiple layers of meaning that might emerge in an interview. Further, similar to Charmaz (2003) and Ellingson (2009), Van Manen (1990) is concerned with the co-construction of meaning, a philosophical orientation that I espouse in this study. According to Van Manen (1990), "the collaborative quality of the conversation lends itself especially well to the task of reflecting on the themes of the notion or phenomenon under study" (p. 98).

In summary, the study of OIDs of ADs employed a qualitative, CGT approach (Charmaz, 2006) combined with dendritic crystallization (Ellingson, 2009). Eight ADs were interviewed, with the goal of building a theoretical framework to explain how ADs develop, and how their roles

shape and are shaped by their organizations. The interviews were organized into themes, using Charmaz's (2003; 2005; 2006) and Van Manen's (1990) techniques. Additionally, a significant narrative analysis was used (Ellingson, 2009), to crystallize the findings. This approach provided the opportunity to uncover the OID process of ADs, and in turn, allowed the researcher and the participants to co-construct an emerging theory to describe this process.

Narrative analysis.

Combining CGT with other forms of data analysis, such as dendritic crystallization, can provide a richer description of the lived experiences of participants (Ellingson, 2009). Ellingson (2009) defines dendritic crystallization as "an ongoing and dispersed process of making meaning through multiple epistemologies and genres, constituted in a series of separate but related representations based on a data set" (p. 126). The goal of this approach is to move beyond simply adding new theoretical knowledge to a field, into shifting perspectives among larger contextual, organizational, or societal constructs (Ellingson, 2009). During interviews with the participants, I asked them to share stories about particular pivotal moments within their organizations. Specifically, I asked them to tell me about a time when they felt very connected to their colleagues, and alternatively, to share a story of a time when they felt disconnected. Both the storytelling process and the topic allowed the participants to voice their concerns in the context of the complex and integrated factors that shape their roles and OIDs.

The significant narratives told by the participants were analyzed using a three-phased approach. First, during the thematic analysis, stories were selected that included a) an element of transformation or change over time, b) contained some kind of action and characters, c) were brought together in a plot line by the participant, and d) included a point or 'so what?' factor (Lawler, 2002). Second, the stories were analyzed for turning points, "moments when the

narrator signifies a radical shift in the expected course" (Riessman, 2003, p. 341). These turning points "can fundamentally change the meaning of past experiences and consequently individuals' identities" (Riessman, 2003, p. 342). Third, participants' stories were examined for acts of meaning (Bruner, 1990). Bruner (1990) contends that narratives can be used by individuals to make sense of their social worlds. Thus, by examining how the participants' narratives helped them to solve problems, reduce tensions, or resolve dilemmas (Bruner, 1990), I was able to further understand how the ADs in this study make sense of their multiple and competing identities and values.

From a discovery standpoint, analyzing these stories in a narrative context offers important insight into the sensemaking process of the participants. Scholars of organizations contend that individuals use narrative as a way to interpret events and infuse them with meaning (Cheney, Christensen, & Dailey, 2012; Rhodes & Brown, 2005; Trowler & Knight, 1999). Weick (1995) argues that stories are pivotal to sensemaking because they are the process by which shared values and meanings are conveyed and organized. Narratives also provide insight into the subjectivity of interpreting events (Weick, 1995). While participants in this study have similar experiences and roles, each of them makes sense of their role within the organization differently. By analyzing the stories most important to the researcher and the participants, the relationship between the individual and collective stories of this group are highlighted. As Mumby (1987) concludes, "narratives do not simply *inform* organization members about the values, practices, and traditions to which their organization is committed. Rather, they help to *constitute* the organizational consciousness of social actors by articulating and embodying a particular reality" (p. 125, emphasis in original).

Further, narratives help us, as researchers, to unpack the complexity of identity. These

stories indicate how the participants in this study want to be known, in relationship to their identities as ADs. Riessman (2003) contends that, during an interview, participants "do not reveal an essential self as much as they perform a preferred one, selected from the multiplicity of selves or personas that the individuals switch among as they go about their lives" (p. 337). Thus, analysis of significant narratives "opens up analytic possibilities that are missed with static conceptions of identity" (Riessman, 2003, p. 337). As a group, these narratives further underscore the importance of Trowler and Knight's (1999) contention that universities have a responsibility to help faculty to unpack the complex messages and structures of postmodern organizations.

Ethical and Trustworthiness Considerations

By using a qualitative and constructivist approach to this study, I acknowledge that my role in the research shapes its outcomes. In this section, I will discuss my experience with this topic, as well as the methods I used to ensure validity in my data collection and analysis.

Holstein and Gubrium (2003) argue, "[f]rom the time a researcher identifies a research topic, through respondent selection, questioning and answering, and, finally, the interpretation of responses, interviewing is a concerted interactional project" (p. 14). Thus, through the process of this study, I recognize both the role of the researcher and the participants in constructing a theory of the OID process for ADs. As an active participant in meaning-making, I come to the study with a series of experiences that inform my perspective. In my work at the Indiana University School of Medicine, I have seen ADs struggle to articulate and understand their positions within the complex system of an AMC. I have spoken with faculty members who often do not choose to highlight education as an area of excellence in their promotion and tenure materials; they claim this approach is just not valued by their departments. I have also been privy to debate

between faculty and the administration of the institution, questioning the level at which they are paid to teach medical students versus provide clinical service. Thus, by choosing to study this topic and examine it through the lens of OID and post-structuralist views of organizations, I am advocating for the voices of ADs to be heard and valued within AMCs. These experiences could be perceived as biases. Alternatively, Holstein and Gubrium (2003) contend that the position of the researcher in action-oriented interviewing is "not viewed as incidental or immaterial. . . . Rather, [the researcher] is seen as actively and unavoidably engaged in the interactional co-construction of the interview's content" (p. 14-15). While I am aware of some of the experiences of ADs in AMCs, I am unclear about the magnitude, scope, and effects OID has on the work of ADs. I have relied upon my data to answer these questions, with the goal that a study such as this has the potential to create change within large and important higher education organizations.

In addition to foregrounding my role in the study, it was critical to collect valid and reliable data on this topic in order to produce a grounded theory that truly reflected the experience of the participants. Yardley (2000) offers four characteristics that proved helpful in ensuring a rigorous interrogation of my research questions. First, the author argues for "sensitivity to context" (p. 219). By thoroughly reviewing the literature on faculty experiences and AMCs, I sought to highlight commonly held assumptions and values. Sensitivity to context is also present in the chosen analysis approach. As Yardley (2000) explains, "the [interviewer] contributes to what is said, not only by the moment-by-moment verbal and nonverbal input which prompts and completes the other's utterances, but also by passively invoking the relative identities and shared understandings which provide the framework for speech" (p. 221). Second, Yardley (2000) contends that strong commitment to the topic and rigor are important elements of good qualitative research. By gathering and analyzing data consistent with Charmaz (2003) and

Van Manen (1990), the study fulfills this criterion. Third, Yardley (2000) argues that transparency and coherence are important qualities of good qualitative research. Again, a reliance on Charmaz's (2003) standards for data saturation, as well as member-checking, are important to ensure rigor. Fourth, is the impact and importance of the study (Yardley, 2000). As illustrated in Chapter 1, I sought to develop a theoretical model to explain OIDs of ADs in AMCs. A deeper understanding of ADs experiences helps both groups—ADs receive more role clarity and individual agency; AMCs receive information on how to better meet the needs of this population. Further, as other professionals are faced with competing roles and OIDs in complex organizations, the outcomes of this study may reveal the experiences of others facing similar challenges.

Chapter 4: Participant Profiles and Significant Narratives

This chapter provides a profile of each of the eight study participants, including their views about their education work, the values they hold, the tensions they feel, and their goals for the future. These perspectives are offered as a way to understand how these faculty members make meaning of their roles in U.S. academic medical centers (AMCs). In addition, using Ellingson's (2009) dendritic crystallization method, one story told by each participant was identified that captured a significant moment in his or her experience as an AD. The purpose of this story identification is two-fold. First, as indicated in Chapter 3, narrative offers important insight into the experiences of individuals within the unique contexts of their organizations. Second, these stories paint a picture of the multiple facets of ADs identification.

Institutional and Participants' Background Characteristics

This study included eight faculty members from four U.S. AMCs. Similar institutions were chosen based on the size of their student and clinical faculty population and amount of NIH funding. Then, the list of institutions was reduced to focus on diversity among geographical location. Institutions with similar characteristics were chosen from each of the following regions of the U.S.: North, West, Midwest, and East. Finally, the list of institutions in each region was narrowed to one per region. To ensure similar missions among the institutions, those with for-profit hospital partners were excluded.

Potential participants were contacted via listserv announcements from the researcher's personal connections in the AAMC Group on Educational Affairs (GEA) membership. Additional participants from those institutions were sought using a snowball sampling strategy. The eight faculty members chosen for this study were diverse in gender, rank, and medical specialty. The study included five men and three women. Three participants were at the

assistant professor level, four were at the associate professor level, and one participant was a full professor. While the participants had diverse titles, the scope of their work fit the definition of an academic director as defined by Schuster and Pangaro (2010).

Table 4.1

Participant Characteristics

Name	Location of Institution	Ownership Structure of AMC	Gender	Rank	Alternative Title	Primary/ Non-primary Care[a]
Al	North	Joint	Male	Associate	Vice Chair	Non-primary
Faith	West	Joint	Female	Associate	Course Director	Primary
John	East	Separate	Male	Assistant[b]	Course Director	Non-primary
Kathleen	Midwest	Separate	Female	Assistant	Course Director	Non-primary
Levi	West	Joint	Male	Assistant	Clerkship Director	Non-primary
Mitch	East	Separate	Male	Full	Vice Chair	Non-primary
Salima	North	Joint	Female	Associate	Course Director	Primary
Scott	Midwest	Separate	Male	Associate	Assistant Dean	Non-primary

Notes.
[a]As defined by the U.S. Health Resources and Services Administration (HRSA), available here: http://www.hrsa.gov/loanscholarships/loans/primarycare.html

[b]Although John is ranked as an assistant professor, he began his career in academic medicine years ago, left to go into private practice, and returned recently.

Two participants in the study practiced in fields considered primary care, and the other six participants practiced in medical specialties. To protect the identities of the participants, the names of their institutions and specific specialty areas were excluded. Additionally, each

participant was given a pseudonym. Table 4.1 provides a summary of participants' characteristics, and a short narrative about each participant follows, alphabetized by pseudonym. Subsequently, each narrative includes details about the participant and their experiences that were pertinent in the data analysis presented in Chapter 5.

Participant Profiles and Significant Narratives

Al: Northern medical school, non-primary care.

A course director and vice chair for education at a Northern medical school, Al had been in his education role for three years and a faculty member for eleven. He had a number of supervisors, and was comfortable with this matrix-style reporting structure, that is common in many U.S. medical schools. Al considered himself a teacher and is energized by his education work, both locally and nationally. Al felt as if he was implicitly socialized into his role, and was comfortable with that process. He was aware of the political nature of his role, and simply saw it as part of the job. When asked about how the ownership structure of his institution affects his work, Al said,

> It makes it very complicated is the simplest answer. In any one discussion, you've got three major stakeholders who may or may not have aligned visions about what ought to happen in this particular situation. So the natural politics become very important, knowing who are the folks who have the resources, who are the folks who are going to make decisions, having open lines of communication with all of those. It varies on a case-by-case basis.

While Al felt most connected with his colleagues in his department, in part because of convenience, he also expressed a clear identification with his national peer group of educators in his discipline. When he had a question or needs guidance about his work, Al chose to connect and disconnect with colleagues based on the question type—he simply went to the person who he thought would have the most expertise. Al's biggest concern was the future of medical education more broadly:

> If our fundamental mission is to provide trained physicians to make sure the [state] has adequate care, how do we train more people as there is less money to do it? We have had many, many discussions about strategically deciding which programs to expand, and if we lose a bunch of funding, which ones will we have to close?

Al's narrative: Collaboration around an event.

The notion of collaboration among educators was a common theme among the interviews. While Al's narrative below details a collaborative educational retreat he and his colleagues plan, other important concepts beyond collaboration emerge. First, from Al's standpoint, the reward of this project was better educational outcomes for the learners in his department; a collective reward, rather than an individual one. Secondly, he seemed to place considerable value on the process of collaborative work, showing the extent to which he is motivated by the work, itself. Here is Al's description:

> Over the last few years we've put together an in-house educational retreat for the faculty in our department, specifically in [my discipline]. In June, we're going to have our sixth annual education retreat. That started six years ago with the former vice chair and me and a couple of other folks. It's morphed over the years in terms of who exactly is working on it; now it's me and another one of my colleagues. The end product is one Saturday a year we get together, and we pick some specific education-related topic.
>
> This year's it's about cultural competency in [my discipline]. We will have a national expert come in and talk with us, but also do a lot of interactive stuff where we're working on our education skills with the idea we'll be better educators and our students will get better. When it all happens, it comes together it's (a) just nice to see a bunch of people getting together in their free time essentially to work on these topics; and (b) hopefully it has demonstrated effects in terms of better outcomes for our learners. Putting it together is a good collaborative process among a number of folks in our department.

Al's focus on the intrinsic value of education was important in this narrative. He articulated its importance, in part, by sharing the longevity of the event, implying that this was a value that is "passed down" through generations within his academic unit and demonstrating the extent to which this is (and/or should be) the value of the collective (both his department and the institution). Further, by articulating a clear connection to the educational mission, Al more firmly situated his identification to the educational values of his role (Scott et al., 1998). By

telling his story in this format, he was situating his identification "in contexts of interaction in the presence of other social actors" (Scott et al., 1998, p. 304), in this case, his colleagues.

Faith: Western medical school, primary care.

Faith's role at her institution was 40% clinical and 60% educational administration. However, much of her clinical time was spent accompanied by learners. She felt supported by both her department and institution. Her favorite part about academic medicine was her ability to walk down the hall to discuss interesting clinical cases or educational problems with both learners and faculty. As an educator, Faith valued an environment in which she can collaborate with colleagues toward a common goal.

Faith was challenged by her physical location. Her office was several miles away from the offices of her academic director colleagues. Though the group met face-to-face once a month, she preferred more opportunities to interact with them.

Like some of the other participants in the study, Faith was aware of the management issues associated with the cost of quality education. She explained,

> Education tends to not pay as much as non-educational endeavors, so from a departmental standpoint, it is always difficult to be able to get the resources to do what we want to do and do a good job. And that's the reality: seeing a patient makes more money than teaching a student.

Faith hoped that the movement toward quantifying the work of faculty (such as creating educational dashboards, similar to clinical dashboards) might help her to distribute educational responsibilities more equitably throughout her department.

Faith's narrative: The politics of education.

Each participant was asked to define the roles of their position. Like a few of the other ADs in this study, Faith talked about her multiple allegiances, not just to formal organizations like the university, clinic, or hospital, but also to her discipline and the values of it. As a primary

care practitioner, Faith felt an important sense of responsibility to encourage learners to pursue that path. At the same time, she described her commitment to a new curriculum initiative at her institution. Then, she was asked, "Do you ever feel like there's a time when it is hard to choose which role you're representing or which area you're advocating for?." It was within this answer that Faith's significant story emerged. She explained,

> Oh, yeah, especially if you're really passionate about one area. It's kind of like politics; you have to be able to say, "I can't get everything I want, but at least what will move the ball forward in the right direction and then we can work on getting all of what I want later. What is reasonable?" Right now, we have a change in our curriculum that's underway, and it is pretty apparent to my department that that change in curriculum is likely going to result in a decrease in the amount of exposure students get to primary care. It's pretty devastating in the university where we're [nationally ranked] for primary care….
>
> In a meeting about the new curriculum, trying to wear the hat of someone who needs to play well in a community to create a good curriculum for everybody, you have to put your hat of primary care, not necessarily on hold, but you have to be able to see why the surgeon needs more time or why we need more time here, but still be able to advocate for your own time. Being able to balance the needs of the all, with your own. So your hat as a person who needs to be able to move a curriculum forward has to play some politics, despite your other hat that says, "We need primary care." We first need a curriculum that works in order for us to graduate a student.

I responded by asking Faith to elaborate, with the question: "What kinds of things did you have to say to that person?" Faith said,

> "I can support curricular change, and I want to be part of the process. I look forward to working with you on the change." But very specifically choosing not to say, "I support what you've said." Rather, "I support the process, and I look forward to working with you." So that you can remain part of the conversation, without endorsing what has already been chosen, the path. But even the fact that you say that you support it…some people say, "You can't say you support it." I don't. It would be bad if curricular reform failed. We would all be out of a job. Yes, I need to support a curriculum change, but I want to support it in a way that still maintains a high value of primary care, I think by balancing those two.

Faith used important metaphors here of "balancing," "moving forward," "switching hats," and "playing politics." These images are not entirely positive, but they are not completely negative either. Scott and colleagues (1998) add important insight to this experience for Faith. Two

aspects of her identity were in conflict here: educator and primary care physician. So, her identification process was to disidentify from one, and simultaneously connecting with another (Cheney & Tomkins, 1987). While she made sense of this process, her colleagues do not exactly understand how this is possible. Faith seemed to have a clear understanding that, in order to get the work of education done, there are many values systems that must be considered. By disconnecting from primary care at this point in time, she increased the salience of her identification as an educator (Scott et al., 1998).

John: Eastern medical school, non-primary care.

John was an assistant professor, having returned to academic medicine after working in private practice for many years. While he was not hired to direct the course, he picked up this responsibility almost immediately after being hired. John identified primarily with his disciplinary colleagues and as a clinician. When asked which parts of his job are most important, John replied, "I couldn't imagine taking care of a patient and thinking, 'This is what I do on the side.' I just couldn't imagine doing that to a patient."

One of John's primary concerns was the lack of funding needed to support faculty to participate in a new curriculum at his institution. He said,

> … I think the university is not prepared to put up what they need to put up for resources. They're hoping that the division chiefs or department chiefs out of the kindness of their heart will find the funds. By the way, this has been a frequent complaint in our curriculum meetings from other course directors.

Despite this concern, John relied on his local colleagues for educational advice. He sought it regularly in course director meetings and via informal, proximal networks. John was honest about his lack of training in education. So, these informal networks have been an important part of his socialization as an academic director.

John's narrative: Just dealing with it.

Depending on the role of academic directors in development of the curriculum, they may feel a part of, or separated from, curricular development. Medical education in the U.S. has become very complex. These shifts are associated both with advances in medicine, as well as pedagogy. The AAMC and Harvard Macy Institute (Harvard, 2014) hold extensive workshops, courses, and training sessions designed to prepare clinician faculty to take on the more administrative role ADs play. Since John did not attend one of these courses, he did not have the discipline-wide view that some of the other ADs in this study have. His narrative illustrated a sense of frustration about the lack of control ADs may have about the curricular direction of the institution in general:

> … the development of the course went in several stages. And the whole thing was handed to me and [a colleague] at one point, and said, "Okay, you guys develop the course." And so we did, and we put a fair amount of thought and work into it. And, at almost the eleventh hour, we were suddenly told, "Well, you know what? Because of the new curriculum, there's not going to be a [discipline] course. You guys are responsible for teaching [another discipline]." And that was just sort of dropped on us with no discussion, to my mind, and no appreciation for the work that had been put in to developing the full course at sort of the last minute. I would say that that was probably a time where we felt, again, the overriding administration of education here really doesn't care. It's just going to be, "Okay, you guys, we love you, but you're our worker bees and just deal with it." And we dealt with it. But yeah, that was probably the least pleasant thing that came to us.

John's story draws on Scott and colleagues (1998) connections between "activity, identity, and observable communication" (p. 324). As this story illustrates, the notion of "we" depends on the context of the interaction. Though John did identify as an educator, in this context, he was connected more closely with his disciplinary colleagues because he was (a) being asked to do additional work, and (b) his work as an educator was not being valued by those in a position of power within his organization.

Kathleen: Midwestern medical school, non-primary care.

As an assistant professor, Kathleen dedicated a large amount of her time (about 40%) to medical student education. Her clinical work stayed at a steady pace throughout the year. However, she did a large amount of ad-hoc mentoring of medical students that tended to increase in the late spring and early summer, as fourth year students apply for residency programs. Kathleen seemed to equally identify with her specialty and her educator role. In fact, there were times when she merged the two, talking about how she felt obliged to encourage students to consider her specialty as a career choice. Kathleen's values system was upheld by her department; she was very committed to incorporating students into her clinical work as much as she could.

Kathleen struggled to encourage her colleagues to participate in more time-intensive teaching activities at times (such as clinical simulation), because it could harm their productivity scores provided by the institution. She prided herself on developing creative solutions to continue to serve students, such as asking retired faculty members to lead these activities. She felt valued in her department as an educator and a person who gets things done.

Overall, Kathleen was one of the most optimistic participants in the study. While she did not ignore some of the real challenges faced by academic directors, she generally felt satisfied by her work. About participating in the study, Kathleen stated:

> I appreciate you doing this kind of work because…everyday things come up where you get frustrated and you're like, 'Oh, well this just another battle to fight or another thing to organize.' Then when you get an opportunity like this to talk about things and you reflect on the big picture, you realize that things are pretty good.

Kathleen's narrative: A family of educators.

Kathleen's narrative dealt with a powerful experience, very recent in her memory. A lawsuit over a student grade had recently been brought against her academic department.

Kathleen alluded to the situation three times during her interview, likely because it was so traumatic and fresh in her mind. She explained,

> At the end of the first day of testimony… [two education deans] didn't have to testify that day, but they just came in and sat with us. I thought that was great. Then during the lunch break, the student was acting as his own attorney, and one of the senior deans said, "You know, we're all sitting on this side of the courtroom ... and we're all like a little family.' … it was interesting to talk about it; it really felt that way. It felt like we were a little family going through something. A super cheesy story, but it's so recent in my mind. We had a de-briefing meeting yesterday, and I felt like we acted like a family between the departments, through the dean's office, even with our legal team, it really felt like it had a family feel to it.
>
> …The thing that really helped the most was they thanked us so much. They recognized that, two departments, as I mentioned, were really targeted, so it was the [department leaders], they just kept saying to us, "Thank you guys for being so strong and for doing the right thing and following this through." They kept doing that throughout this whole process. Checking on us to make sure we're okay, and lending any support they could. That support was their time, and just their presence, and then thanking us profusely. Those three things were really, really helpful.

In this narrative, another value emerged: non-monetary support of education. Kathleen was invested in the school and the outcome of this situation, a seemingly difficult one for all involved. Scott et al. (1998) argue, "the activities that define our situations shape and are shaped by the social interaction that is so important in the identification process" (p. 324). In this example, Kathleen's identification with her institution and her role as an educator were reified by the support she received from her colleagues and her deans. Her impression of the education unit within her institution was improved by this experience, in part because she was able to situate this positive and collective image next to the image of the student who brought the lawsuit sitting alone.

Levi: Western university, non-primary care.

Levi was an assistant professor who spent about 70% of his time on clinical care. He worked in a demanding specialty area where his schedule was organized monthly, rather than daily as some of the other study participants. Levi spent three weeks per month in clinical care,

and one week per month on academic and administrative duties. He was a relatively new clinician, and was still energized and excited about patient care. The responsibilities of Levi's position made it difficult to manage. When asked how he managed busier times of the year, Levi answered,

> With difficulty. For example, right now, coming up in June and July we have a couple of our faculty members are leaving. We have new ones coming on, but they don't come until August, and it's a busy clinical time for us. I still have to do the basic requirements for my clerkship directorship and that's basically orienting students. But certainly, I do fall behind during those busy clinical times.

Levi's most rewarding experiences were associated with learners. He especially enjoyed mentoring students to consider going into his specialty. At the same time, he was practical about the fact that his educational work did not generate enough funding to make the department run. He admitted he had some opportunities to learn to better negotiate the value of his educational work:

> Well, what I do with education doesn't really reimburse the department very much. So…clinical production becomes a big priority, I think, for any department. In terms of negotiations with the department and the chair, I do feel like that's something that I have to sell. Something that I probably need to do a better at is negotiating how important my job is, even though it doesn't bring in clinical revenue.

Levi's narrative: Negotiating commitments to department and school.

Levi's narrative illustrated the profound importance of ADs to successfully negotiate between their academic department and the medical school. In his story, the Liaison Committee for Medical Education (LCME) required his institution to adjust a teaching technique or risk their accreditation. But his vice chair in his department disagreed with the process change. He explained,

> It is never that black and white, but there is that subtle case. Last year, we had an LCME review, and one of the mandates was [a particular clinical experience for students]. So, that really came as a mandate that we have to fix that, from the dean's office. And, the vice chair of education (the person I usually use as a mentor) just thought it was a silly idea, that people just don't have time for that. But it was really a mandate, not optional,

> from the dean's office. So, I had to go about making that clinical change. She wasn't against it, but certainly wasn't supportive of it. It is what I perceived on my own, and accomplished it. I think that is one example where the dean's office says one thing but I don't get a whole lot of support from the department.

When asked about the effect the mandate had on his work, Levi said,

> If I had more 100% department approval that would make it easier for me to go to different physicians and say, "This is a new requirement; this is a new rotation; this is a requirement for your job." But, without the approval from the department or from a chairman, for example, I can make that request, but there's not really a lot of support behind that request.

I followed up by asking how he made the decision to do it, in essence allying with the dean's office, as opposed to his vice chair. He replied,

> When I looked at the report it was clear to me that accreditation is, in some way on the line. And, if that's the case, when you are talking about something that important, I don't think there are too many options.

The development of organizational identification allows individuals to commit to their various roles and responsibilities. Cheney and Tompkins (1987) explain that the ongoing process of identification "involves, among other things, the selection and management of particular commitments—commitments which are made toward actual or potential targets" (p. 7). Thus, by committing to carry out the recommendation of the LCME, Levi was aligning with the dean's office (and the medical school), and disidentifiying with his vice chair (and his department). While this shift was subtle for him, he did not perceive many options. This lack of choice could create ambivalent identification (Kreiner & Ashforth, 2004) for ADs who have trouble managing their multiple targets.

Mitch: Eastern medical school, non-primary care.

Mitch was the only full professor in this study. He had been involved in medical education for most of his career, though he believed he was appointed to his current role because he was at the right place, at the right time. Mitch's role was robust. He had a joint appointment

in two departments, co-directed two courses, and served as the vice chair for education in his department. Mitch did not censor his perspectives about funding and education at his institution. He preferred not to deal with financial issues associated with educational efforts or clinical care, willingly leaving those responsibilities to his chairs.

Mitch felt very strongly about keeping his 40% clinical time consistent; any less, and he believed he would not be able to perform effectively. He considered his situation unique because he was the only person at his institution that could teach his courses. He equated his value with necessity:

> The chair in [one department] I'm sure is very happy with my work because I'm the most cost effective person he's got. The various deans are very happy that I volunteer to teach [courses] because, of course, I'm not required to do so. I do so because it's fun. …our current chair [of my other department] inherited me. He probably is not in much of a position to say, 'the department can't afford for you to be out of the [clinic] so often,' because that would really piss off the medical school.

Mitch's closest colleagues were those with whom he teaches. He and his colleagues intentionally created a community, sharing ideas in a sub-committee structure and celebrating together when the course ends.

Mitch's narrative: Somehow finances work.

Mitch's narrative came in response to the question, "How do you know that you are appreciated?" His story was an important illustration of the structure of finances of the institution. For Mitch, he was perfectly comfortable not knowing how he was paid, in part because his security comes from knowing that his clinical knowledge and skills are difficult to replace.

> The dean of the medical school and the chancellor always go out of their way to pat me on the back. The reason why I'm laughing is because the second year medical students put on a show every year where they tend to roast and make fun of the faculty and the institution and whatever. Because it's pretty easy to caricaturize me, I tend to be (or somebody playing me tends to be) one of the stars of the show. Of course, the dean always gets the brunt of their humor also. At last year's show, I was actually sitting with

> the dean and the chancellor as we were all getting lampooned, and both of them separately turned to me and said, "This is a sign of true love. They wouldn't pick on you like that." These guys, who ultimately hold the purse strings, are obviously appreciative of what I do, and somehow, help my chairman make it financially viable.
>
> Just to give you an example, the other vice chair in my department, who's the clinical vice chair, she also has another title outside of the department where she is called the Medical Director of the Operating Room. That's an enormously time consuming administrative job, but a huge fraction of her salary comes from hospital administration, and they funnel that into the department to free up her time to do that. I am not privy to just about anything economic in my department, and that's fine with me. I'm not an economics guy, I'm not a money guy. I also don't have to worry about making enough money to make the payroll which is the most important job of the chairman, so I don't really know exactly in the nitty-gritty sense how these things are happening. I'm assuming, I can only assume, that they're happening in such a way that the chairman decides that it's financially viable.

Mitch's willingness to disengage from the financial aspects of the organization represented an important location of disidentification (Kreiner & Ashforth, 2004). By having "nothing to do with the money," Mitch was avoiding having to make certain choices about his time and priorities. He constructed this story as one in which the individuals in a position of power make decisions about the values of the institution, and situated his work within it. Alternatively, he could have perceived this lack of information as threat to his role within the institution. Mitch's construction of the story about the medical students' roast and his subsequent conversation with the dean and the chancellor illustrated the extent to which individuals adapt identity narratives as a way to fit evolving perceptions of self (Ashforth et al., 2008).

Salima: Northern medical school, primary care.

Salima served at her medical school for eleven years, and was hired to spend 25% of her time on curriculum development. Over time, the scope of her education role changed, such that her time was now split into half clinical service and half educational administration. In the time leading up to our initial interview, Salima struggled to keep her amount of clinical productivity "in the green" (her institution uses a red, yellow, green coding system). She was unsure of how

this would affect her annual review; however, a portion of Salima's pay was tied to her clinical productivity.

As an educator, Salima felt more closely connected to her colleagues within her national organization than she did her local colleagues. However, she did have a local mentor that she trusted for feedback and support. Like some of the other study participants, Salima's role had a matrix reporting structure. For her clinical time, she reported to one person; but, for her educational efforts, she reported to someone else. Balancing and negotiating these multiple roles was a source of frustration at times.

Despite these challenges, Salima seemed energized from all parts of her work. She enjoyed developing new curricula and mentoring students. Salima's relationship with her colleagues in her national organization was an important stabilizing force in her career. As she considered options for what her next role might be or where she might fit best within medical education, she relied on colleagues in a national organization to offer advice and support her.

Salima's narrative: Not feeling alone.

Salima's story also represents the narrative's role in creating continuity of self. When Salima was asked, "Who do you feel most connected to? And why do you think that's the case?," she told a story about not being selected for a new position within her department. Her news encouraged her to connect with individuals both in and outside her university, while simultaneously disconnecting with her department and discipline:

> Recently I had applied for a position in my department and did not get that position, and that's been very challenging. I am trying to work to process this. So, I went out to lunch with a friend in the medical school who is an associate dean. The conversation we had was one in which she really understood how hard this was for me on a personal level, as well as being able to have enough professional insight in terms of what her leadership role is and understanding this, to be helpful in that conversation and provide good advice. …I found out I didn't get this job when I was at a recent national meeting, and it was just nice to have a few people there who I could share that with, real-time. Again, it was that

> idea that you realized you're valued. It's hard initially. You're like, "Wait a second. What happened here?" For you to be in a place where you're valued, and people know the work that you've done, I think that was also a very helpful place to be. Just to be able to be comfortable enough to share that information and to have those relationships and those groups has been very helpful. For me, a lot of it is just not feeling alone.

Like Russo's (1998) study of newspaper journalists, ADs do not focus their attachments solely on formal targets, such as their institution or profession. Rather, their multiple attachments with medical educators, both within and outside their institution, are incorporated into their organizational identification process. Further, Salima's story illustrated that the boundaries between the constructs of what is an organization and what is the AD's profession are not clear-cut. The organization can sometimes be understood as the department, the medical school, or the AMC. Similarly, the profession could be the discipline or the field of medical education. Overlap between these targets of identification create further complexity for ADs.

Scott: Midwestern medical school, non-primary care.

Scott's title was assistant dean. Like Faith, he was responsible for a particular part of the undergraduate medical curriculum at his institution. He worked clinically 25% of the time, and spent the reminder of his time with various educational efforts. Scott used his multiple organizational perspectives to work as a diplomat across the system. He explained,

> Maybe because my allegiance isn't so strong to any one group, I'm able to continually keep the big picture in the forefront. When any one group seems to be straying or it seems their word choice is such that it may disadvantage one of the other groups, I can bring it back to center point.

This was a role Scott seemed to enjoy playing within his institution. Additionally, Scott had an interest in innovative medical student curriculum and in educational research. His institution had been generally supportive of these pursuits. That said, he found intrinsic rewards in his work: "…the reward I get is first and foremost personal satisfaction of either advancing someone's career or advancing an organizational wellness."

While Scott did not seek out a role in medical education when he left residency, he believed he had an innate set of communication skills that served him well in these roles. He valued and enjoyed his time mentoring students, and wanted to move medical school curriculum in the direction of fostering leadership and change management skills. Scott was driven to make sure he had a professional network that met his needs. During different parts of the conversation, he expressed how he consults different mentors at different times in his career to achieve the results or outcomes he is seeking. These mentors were from his department, institution, and national disciplinary organization.

Scott's narrative: In a position to lead.

Scott's story took a different perspective on the role of ADs. He felt empowered, through his role, to be able to offer suggestions for how to make curricular change at his institution. He explained,

> I think anytime you're in a leadership position, you get to look at the curriculum, and if you want to take it in one direction, you just start the conversation and you steer it and you push it and you say, "Wouldn't it be cool if we did this? What if we formed a working group?" …I've learned to be cost conscious at [my institution] so finding these big picture things that have minimal financial impact, but hopefully maximal emotional or intellectual impact, is important I think. …when I moved out of the residency and into the med school, one of the first things I did was ask, "how do we more effectively use this time, and how can we do it in a really novel and engaging way that the students will feel empowered and can really take it to the next level?"

At that point, Scott described a new curriculum he developed for fourth year medical students, allowing more customized and measurable experiences for students. After describing the program, he ended with:

> I think it's innovative, and it gives me energy to build this structure that is innovative, yet engaging. And I couldn't do that if I wasn't in a leadership position. Or, if I did want to do it, the hurdles would be much greater.

Of all the individuals in the study, Scott's sense of agency within his role and institution seemed to be the strongest. Rather than seeing his position as a go-between or middle-man, Scott viewed

his AD role as an opportunity to be innovative. Scott's understanding of his role within the medical school and AMC was suggestive of Ashforth and Johnson's (2001) discussion of holistic identities. Rather than seeing his roles as educator and clinician in conflict, Scott perceived his movement as seamless, "where the boundaries around each identity fade and the contents flow into a rich mélange" (p. 47). His experiences working at a safety net hospital seemed to inform his frugality in curriculum development; simultaneously, he incorporated his work with curriculum into his patient care responsibilities. This role blending may be an important key in helping ADs to feel a sense of efficacy in a complex system, with multiple targets of OID and reporting lines.

Chapter Summary

The aforementioned profiles provided context on how participants in this study situated themselves in their roles and institutions. As Schuster and Pangaro (2010) note, academic directors (like those studied here) play a critical, liminal role within AMCs. They communicate down the pyramid (see Figure 1.1) by developing rank-and-file medical educators' skills in student assessment, instructional strategies, and curriculum design. They also played a key role liaising up the pyramid, by providing perspective on the educational mission of the institution to academic deans and administrators. While this in-between position can be powerful, it is not without unique challenges. Academic directors can feel isolated, because each institution might only have a handful of individuals who serve these functions. Diverse responsibilities of ADs might also mean that their paths to promotion are unclear or tenuous.

The ADs in this study presented many of these responsibilities and challenges. As a group, they enjoyed both clinical care and education. They seemed to find energy in collaborating with colleagues to solve problems. They were intrinsically motivated. Many of

the study's participants also faced similar realities. They were not necessarily trained for their jobs, and their education work did not generate revenue for their institutions. The complex, postmodern structure of AMCs presents challenges for ADs' supervision and upward mobility.

Reviewed separately, each of the stories offer one lens through which to view important experiences of the individuals in this study. But, taken together, these experiences paint a picture of the complexities that exist for ADs in AMCs today. Cheney and Tompkins (1987) contend that organizational identifications are constructed socially, via the interpretive perspectives of others. Narratives and storytelling are an important part of this process. Identity is created and reified by the stories we tell ourselves and others (Cheney et al., 2012). In organizational identification, individuals use narratives to make sense of events over time. This process of connecting to and becoming a part of an organization is often best told in narrative form, as it allows for focus on the process and interplay between individuals and organizations. Ellingson's (2009) dendritic crystallization techniques were especially useful in the narrative analysis portion of this study. By moving back and forth between the constructivist grounded theory theme and concept analysis, into the narrative analysis, data were examined from several perspectives. This technique is especially useful when providing the thick and rich descriptions required of qualitative research (Ellingson, 2009). The analysis of these moments of connection and disconnection illustrate the extent to which identification is socially constructed and influenced by a variety of individual and organizational factors.

In the subsequent chapter, interviews with the study participants are analyzed by theme to address three research questions: (1) how does one become an AD?; (2) how do ADs manage multiple sites of organizational identification (OID)?; and (3) how does the context of academic medicine today shape the participants' roles and values? Ultimately, a conceptual model is

presented to depict the complex relationship between individual and organizational factors that affect OID.

Chapter 5: Negotiating a Fit: Study Findings

The focus of this study was to develop a robust understanding of the OIDs of ADs in U.S. medical schools. This chapter includes the results from semi-structured interviews with eight ADs from four, varied AMCs across the country. The results seek to answer the following research questions:

1) How do academic physicians become ADs?

2) How do ADs make sense of their multiple targets of OID within AMCs?

3) How does an AMC context shape the roles and values of ADs?

A constructivist grounded theory (CGT) methodology (Charmaz, 2006) was used to analyze the interviews, and dendritic crystallization techniques (Ellingson, 2009) were used to respond to the changing nature of the project. As such, the data were analyzed using both a traditional thematic analysis (Van Manen, 1990) and a narrative analysis (Charmaz, 2003; Mumby, 1987; Riessman, 2003; Rhodes & Brown, 2005). In this chapter, a comprehensive examination of each core category and theme is offered as a way to illustrate the relationships between the role of the AD, the socialization process, and the organizational context that shapes the role. As illustrated in Chapter 3, the identification process for ADs in today's AMCs is complex and evolving, perhaps containing multiple inconsistencies and incongruities among individuals. By combining the narrative analysis in Chapter 4 with the subsequent thematic analysis, I sought to clarify the relationships between the internal identification processes of the study participants, with the powerful contextual forces at play (Ellingson, 2009). Lastly, the chapter concludes with a brief overview of the connections among the themes and narratives with a presentation of a constructivist grounded theory.

Analyzing the interviews for themes revealed three core categories that illustrate the interconnected nature of ADs process of becoming and then managing multiple sites or targets of OID. First, the theme of *socialization*, with a focus on implicit rather than explicit development, was apparent in the interviews. Secondly, the data indicated that participants regularly *struggled to manage their OIDs*, specifically when asked about time and the organizational location of their roles. Third, when asked about their values in comparison with those of the organization, participants discussed both *intrinsic and extrinsic contextual factors that shape their values and the perceived values of the organization*. The three core categories (socialization, managing multiple targets of OID, and contextual factors that shape values and role) are presented subsequently, with specific subcategories and verbatim examples from the participants.

Socialization

For the participants in this study, the socialization process for becoming an AD was haphazard and often lacked a clear pathway. Three sub-themes illustrated the implicit socialization process: 1) *falling into medical education*, 2) *learning on the fly*, and 3) *unclear expectations*.

Falling into medical education.

All of the participants in the study expressed a sense of serendipity when talking about their careers as academic directors. Most described their path as one where their role grew over time. John, Mitch, and Levi indicated that they became academic directors, in part, because there simply was not anyone else to do the job. John describes this best, "I raised my hand, and the next thing I know, I have six years' worth of course syllabus plopped down on my desk."

Others felt that they had been tapped for a leadership role in medical education because they showed an interest or had experience (such as serving as a chief resident) that led them to

the role. Both Scott and Kathleen agreed that they were at the right place at the right time. Kathleen said, "The opportunity came up and my chair asked me if I would be interested because I had gotten positive evaluations from residents and students for teaching efforts." Others mentioned personality traits or intrinsic qualities that made them well-suited for leadership in medical education. Scott attributed his appointment to his communication skills:

> I seem to be able to relate very well to students and to faculty. And I seem to be able to manage up and down. And so it was quickly, I think in some way or another, the senior faculty at [my institution] identified that and promoted it, because I quickly went from an associate program director to program director.

Alternatively, three participants entered into their role because they were already doing the job for a period of time, sometimes with no title and compensation at first. Faith explained that she chose to lobby to be paid for work she believed in. Faith described her situation like this,

> Just by showing up, I was seen as unusual. I'd say, "What can I do, how can I help?" By being present and active and enjoying it regardless of how much time I was given, I was seen as someone who was invested in teaching.

While Faith implicitly connected teaching to support by indicating that she had to be "given time" to teach, Salima more explicitly connected the need to ask for funding to keep doing her education role. She stated,

> It was matter of going to someone and saying, "This is the work I have done. I need something to come back for it otherwise I am going to have to not do it." So, that was the beginning of the story. Soon after that, the medical school got grant money to [develop curriculum in her area of interest]. So I think you have to be flexible in what you want to do in order to be supported for doing it, and I enjoy being flexible. That is part of the challenge and the creativity part.

In both of these situations, the work of education was seen as an extra, something that these individuals felt so compelled to do that they chose to advocate for its support.

Regardless of the path, it is telling that no participants explicitly sought out a role as an

AD. They all seemed to enjoy teaching early in their careers; some specifically chose a position at an AMC to make sure education was a part of their work; and even a few had mentors that steered them toward educational leadership roles. Yet, no participant stated that they sought out medical education as a career path.

Learning on the fly.

MacDougall and Drummond's (2005) qualitative study of the learning history of medical teachers provides important insight into the experiences of participants in this study. As health care becomes more complex, there is a need to encourage young physicians to work in new ways. Team-based care, technology, and new payment models are all changing the ways in which health systems function. To improve teacher quality requires a level of attention to how future academic directors enter the field and are trained.

Within the past 25 years, a number of disciplinary organizations have developed courses, publications, or learning communities to provide formalized training to academic directors. The Alliance for Academic Internal Medicine (AAIM) has been at the forefront of this effort, working with a number of other academic medicine organizations to create the Alliance for Clinical Education (ACE) in 1992. This group developed the *Guidebook for Clerkship Directors*, a resource designed to provide "advice and practical solutions to the issues that affect clerkship directors across disciplines, including orientation, curriculum, evaluation, instructional strategies, role of the director and administrator, and faculty and career development" (ACE, 2010). Additionally, the Harvard Macy Institute (HMI) was established in 1994 with a grant from the Josiah Macy Jr. Foundation. A collaboration between the Harvard Medical School, the Harvard Graduate School of Education, and Harvard Business School, the institute is designed to provide professional development for leaders in the academic healthcare sector (HMI, 2014).

While only three participants participated in a formal course like those described above (John, Levi, and Kathleen), almost all of the participants (Al, Faith, John, Kathleen, Levi, Salima, and Scott) made use of the educational resources of their disciplinary organizations. They all agreed that this approach was useful in orienting to their roles, yet not exactly an organized approach. Scott explained, "I quickly got involved in a national organization and took on a board member position in our national organization on the state level. That gave me on-the-fly training." Scott's comment was interesting, though, because it illustrated two important sub areas of this theme. The participants in this study felt as if they were required to learn on the job, and most of them were unclear about the expectations of their role.

Six participants indicated that much of their socialization as an academic director is a process of trial and error, with a bit of testing and feedback mixed in when available. Al explained that, at his institution, directors were usually implicitly socialized during clerkship directors' meetings. He described this scenario hypothetically:

> You go to a course director's meeting and see the different personalities. You see how issues seem to get addressed by folks in charge of the committees. What are the issues that seem to be on the table…and how are issues resolved? …Probably a good chunk of that and then a lot of you know trial and error. Trying something with a course and getting feedback and seeing how leadership responds to that feedback and what the expectations are in improving the course.

Kathleen, on the other hand, received very little in the way of training. She said, *"*As a resident, I had a resident-as-teacher series as part of our lectures, so that's really the only formal training I've had in terms of clinical teaching. The rest has honestly just been completely on the fly." Mitch concurred, "When the new curriculum was designed, I was appointed [in my area] to be the director of the first year course, and since everything was being revised from scratch, we pretty much learned as we went." This lack of formal training often leads to confusion about expectations for ADs (Schuster & Pangaro, 2010).

Unclear expectations.

The participants in this study all had responsibilities in multiple areas of the institution, including providing clinical care, developing and managing curricula, working with medical students, and conducting educational scholarship. The percentage of time faculty members devoted to their AD role varied from 20% to 75%. Some of the participants in this study did not have a position description when they took on their role of academic director, others wrote one on their own when they took the job.

Levi, for example, received advice from his disciplinary training course to get a clear set of expectations. He explained,

> Well, you know, actually they didn't [give me a job description], but through this course I took, I learned that was an important part of doing your job successfully. And so, I talked about that afterward, you know, after I already started the job, I got a defined list of responsibilities.

For Kathleen, not having clear expectations is comfortable. But, she concedes that this type of environment is not for everyone. She said,

> …my department has been very nebulous [about expectations], and I think a lot of it has to do with setting your own self-expectations and then trying to follow through on that… For other faculty who need a lot more direction, not having anybody directly guide them in those goals could be difficult and frustrating. I think that mechanism is what exists right now. It works for some types of people and not so much the other types.

Salima also acknowledged the lack of definition in the role. However, she framed it in a positive light, as a "learning process." She went on to compare the level of clarity in a previous role with her current one. She explained,

> I think for this role that I am in currently in, it was more well-defined because there was a program to run, there were students that were coming, there was curriculum that needed to be tweaked and managed. But for the rest, I can't say anything else but self-defined.

Alternatively, Scott found the lack of clarity in his role to be liberating. He said,

> [My job] didn't exist before, so I could literally go in and just create my own role. It was in the dean's office, which was great, and it was a director position. I got fortunate enough to get it, even coming from outside, coming from an affiliate institution.

In summary, the individuals in this study seemed to have varied and unclear expectations for their AD roles. Whether this ambiguity is positive or negative often relies on the individual's perspective.

Sense-Making and Multiple Targets of OID

The experiences of ADs in this study are complicated on two levels. First, ADs are managing their identities as physicians, teachers, educational administrators, and disciplinary citizens. In this first level, the challenges occur for the individual. Second, ADs function within multiple organizations: departments, universities, hospitals, and disciplines. While the socialization theme focused on the individual participants' ability to acclimate into the role of AD, this section will focus on how the participants make sense of their multiple identities, in the multiple organizations (or targets) of identification. Two sub-themes emerged in this category: 1) *not enough time* and 2) *where and how do I fit*.

Not enough time.

The academic directors in this study, like many academic physicians and faculty in higher education, felt more pressure on their time than ever before. These time pressures shape the ways ADs, in particular, manage their multiple targets of OID. One influence on an AD's ability to manage time is the type of education responsibilities of the AD. For example, in this study, John, Levi, and Mitch's courses were always taught at the same time of the year. So, their workload increased leading up to the course and during the teaching, but decreased dramatically through the rest of the year. The balance of patient care, teaching, and academic responsibilities was also influenced by medical specialty. Anesthesiologists cannot answer emails in the

operating room; however, a general internist might be able to speak quickly with a learner about their grade in between patients. For the participants who were in surgical specialties, it was nearly impossible for them to complete administrative work during their clinical time. So, the separation of their work is very clear. As Mitch explained,

> Typically, I'm in the operating room two days a week, and when I'm in the OR, I do nothing else. That leaves three days a week for administrative stuff, teaching stuff, everything that doesn't involve working in the operating room.

Although this kind of specialty created some separation, there were always moments where balance is required. Levi, for example, described a patient care emergency as something that always trumps administrative or education work. He explained further,

> It is difficult. Today was my administrative day, but I had an operation scheduled because I'll see people in clinic and they'll need an operation. …It certainly bleeds over one way or the other. When I am on clinical service, I have my smart phone, and I am frequently answering emails and students want to talk about their grades.

The faculty members in this study experienced the balancing act of education, service, and research at a higher level than faculty at large. When asked about changing the structure of his time to more effectively balance his workload, he replied, "…there's not a lot of choice in the matter." Upon further probe, he stated,

> I could give up teaching but, first of all, I'd be a lot less happy, and the medical school would be up a creek. That's just not a viable option right now. I can't justify giving up any more clinical work. …I know people at other institutions who may show up in the operating room a couple of days a month and they're probably dangerous. So that's not an option. That's really why there's really not much I can do about it. At the times of the year when I'm busiest, there's not much I could give up.

This incredible pressure is telling, and echoed throughout the participants' interviews in this study. Involvement in the education mission makes ADs feel satisfied. Realistically, though, there is not enough time available to do all of the work effectively, and the education mission is likely to suffer at the expense of the clinical service mission.

The lack of time needed to effectively carry out the education and clinical service missions seemed to create an ambivalent identification for ADs (Kreiner & Ashforth, 2004). Academic directors are often the most appropriate individuals, because of their roles, to negotiate to manage time for education effort. Al explained this negotiation as such:

> Any discussion about how much time does one need for education stuff versus seeing patients is always fraught: there's money on the line and there are plenty of good arguments both ways. If we see more patients, more patients get faster care, better access to care. …My role is to be the advocate for as much time as I think is necessary for people to do a good job with education, recognizing that I won't win all those arguments and that people will end up with not the amount of time that I thought they should have had for education.

The need to advocate for time is embedded in a variety of tensions felt by participants in this study. The concept of ambivalent identification and the tensions associated with ADs' roles will be discussed further in the subsequent themes.

Where and how do I fit?.

In addition to the perils of managing the amount of work required, limited time available, and the pressure of each area of responsibility, ADs in this study found themselves within a precarious place organizationally. For a few individuals, their department chairs viewed education as a responsibility of the school, not necessarily the responsibility of the department. On the school level, the amount of time they had dedicated to educational pursuits was limited and often not fully reimbursed. In other words, the ADs in this study earned more money for their departments by seeing patients in the clinic than they did by educating learners or completing administrative tasks. Participants often felt stuck, with their loyalties divided among their department, the educational mission, and the hospital in which they work. The following four sub-sub-themes further interrogate these dialectics: 1) struggling to find a home, 2) managing multiple perspectives, 3) learning to fight for support, and 4) unavoidable tensions.

Struggling to find a home.

Four participants in this study described a situation where they did not feel as if they fit within the current structures of their organizations. Two participants, Salima and Scott, spent a large portion of their interviews discussing the feeling of being "in between" the parts of the organization. Since Salima is at a transitional point in her career, she spoke specifically about which part of the organization to "make her home," the school or her department. She explained,

> I've made my academic home my department, more than the medical school. I'm not sure if the vision that I have around education is one that matches what the department vision is. In some ways it's challenging, feeling like I made this my home, but maybe this really shouldn't be my home. Maybe my home should be more at the medical school?

This perspective illustrates the struggle Salima faces in her identification process. The complexity of her AMC makes it difficult for Salima to choose which part of the organization to make her primary attachment. Alternatively, Scott did not find his role in between the department, the school, and the hospital system to be problematic at all. Rather, he was "immensely satisfied" to feel that he is "transcending his specialty." Scott discussed his role in between the parts of the organization as a position of great power, one that he is perhaps not ready to take on. As Scott explained,

> You sit at the table with [other specialties] and you have these discussions about the health and the wellness and the strength of the organization and the educational program that you never thought you'd be having, and you never thought you'd be looking at in the way that you are. …I've had this conversation with my wife where I've said, "It's weird to be somewhere you've never trained to be.' In a sense you're like, "Am I a fraud?" Because I don't have training to be here. What happens if all of a sudden the rug gets pulled from out from under me? I guess I can rely on that clinical, that experiential learning but it doesn't feel as tangible.

Thus, for Scott, the experience of moving between his identities (from AD to faculty member to hospital employee) and sites of identification (from school to department to discipline to hospital) took emotional labor, but was also rewarding.

Managing multiple perspectives.

Seven of the eight participants in the study discussed situations in which they were required to live between camps of individuals within their organizations, advocating for different positions or values depending on the context of the conversation. Al explained how he saw the potential conflict between the amounts of time needed for education versus patient care. He stated,

> We have fundamentally a clinical mission, and that's probably where most academic departments' revenue comes from. …[they] are going to be in tension with each other, so the time that I spend on education administration is time that I don't spend seeing patients and there's a tremendous need to see patients. So those things do end up potentially competing with each other. Sometimes there are opportunities for things to overlap with each other and synergy and so on. I think most of the time it just comes down to there are x number of hours in the day and x number of resources in a department. …I think as long as people are open about that and there are processes in places for making decisions about how to resolve these tensions, then I think that's the best we can hope for.

Al understood that education could not be the top priority all the time, so he argued for a scenario that kept all areas of the organization supported. Scott also described how he is able to be empathetic because he maintains multiple roles within his system. He said,

> It means a lot to me to be able to put myself in someone else's shoes and say, "Why are they thinking the way they're thinking? Why are they acting the way they're acting? What's driving their decisions?' If I can understand that I can hopefully engage them in a way that they'll be satisfied with and we can come to a mutual agreement.

While Scott was focusing on compromise, other participants in the study discussed situations where one organization within the hospital system required their advocacy. As individuals who move between multiple organizations within the system (the university, hospital system, education mission area), ADs are often uniquely situated to provide multiple perspectives. Scott, for example, worked at the safety-net hospital within his AMC, a small clinical partner of the medical school, in comparison to the other facilities in the system. This role also required advocacy at times. He explained,

> We had somewhat of a summit of the [strategic planning] task force chairs, and it seemed consistently it was the school of medicine, university, and the children's hospital. Finally, I stood up to the mic and said, "I think we would be making a grave mistake if we don't considerably reflect or considerably pay attention to the opinions of [the safety net hospital] in this situation." Then I voiced what I think are the opinions. I don't have any sort of official role to represent [the hospital]. It's more so just continually riding the ship, "Don't forget, [the safety net hospital] is one of our primary affiliates."

The ability to see and balance multiple perspectives within their system seemed to be an important aspect of ADs' responsibilities.

Learning to fight for support.

Four ADs in this study mentioned the need for advocacy skills in their roles. In some cases, participants were asked to advocate for themselves and financial support of their work. In other situations, they advocated for support of the educational programs that they direct. Mitch, for example, had recently been advocating to the educational affairs unit in his institution to keep a contract faculty member critical to the effective delivery of his course. He explained, "[w]e're going to have to fight really, really hard to preserve this one position that's getting eliminated. And there's no guarantee that the various deans are going to try to come up with the money to preserve this position." In this case, if the 'various deans' did not provide support, Mitch would be required to take on more teaching himself and ask his colleagues to take on additional educational responsibilities without providing any additional release time or a decrease in clinical load. Salima also lamented having to attempt to protect her time. She felt as if she is constantly balancing her education and clinical roles, unclear about how she will be paid. She explained,

> The biggest challenge I am feeling right now is always feeling like you have to figure out how you are going to protect yourself to do the educational mission. That whole ongoing negotiation process can get kind of tiring in some ways. I just feel like, "Whatever. I am just going to do what I want to do and if somebody pays me for it, great. And the other part of me is feeling like, "You can't be stupid about this. You really do need to take time to advocate for yourself. Think about what might happen next year or the year after." It just can be really tiring.

This story is a powerful one. Salima was spending an incredible amount of time and energy advocating for the support of her own job. Kathleen as in a slightly different situation where she was fighting for the philosophical support of others, rather than financial support. From her standpoint, neither the department nor the institution had a sense of just how much advocacy was required to direct her course well. She explained,

> I guess this is a constant struggle. We've always had too few sites for our students, and we are encouraged, as [academic directors], to go out and recruit new sites in the community. It's just been really, really challenging. We'll try to recruit sites, we'll spend tons of time visiting the site, doing faculty education, and then it will fall through.

On the other hand, Faith described her role as an AD as something she was asked to do, but might not feel the close ties with the work that the other participants describe. Tellingly, she uses the metaphor of having multiple children (parts of her faculty physician role) within the institution, and she struggles to attend to them all successfully. When asked why managing her time was so hard, Faith said:

> Probably because it's so divided, figuring out where my priorities are becomes difficult. So making sure I tend all my children, but also give them each enough time to nurture them (children being parts of my role). I don't enjoy the directorship as much as the other roles, but I'm doing it because I was asked to do it. It's hard for me to spend time doing that because I don't love it as much. Of course, a stepchild.

As these experiences illustrate, the individuals in this study were expected to shift identities regularly. The combination of fighting for support, coupled with the tensions many academic physicians face, makes it difficult for ADs to feel settled in their roles and comfortable in the structure of their organizations.

Unavoidable tensions.

Structurally, the ADs in this study faced tensions within their roles, since most essentially have three jobs: to see patients, to direct a course or clerkship, and to be a faculty member. All of the participants mentioned the tension associated with clinical responsibilities and education,

not just for ADs, but for all faculty members. Al spoke very specifically about the tension that many faculty members feel between educational and clinical responsibilities. He explained,

> I think the opportunities are there for faculty to have all kinds of discussion about education. …how much people avail themselves the opportunity really just depends on what they view as their primary role and what the pressures are in terms of seeing patients or doing research.

The tension between teaching and research was more salient for Salima. Early in her role, when she asked faculty to participate in education efforts, they often refused. Working with learners slowed them down, putting their productivity scores below the expectations set forth by the hospital system. At Salima's institution, this was called "the red zone." She explained,

> … the clinical pressures were preventing some of my colleagues who wanted to teach in the clinic from teaching, and maybe it was a little bit financial. It was this idea: "If I teach, I am going to be in the red zone, and I don't want to be in the red zone." Even if it didn't even have anything to do with the money, it was that idea that "I don't like being in the red zone." The other reality is that we needed these teachers. I needed people to take students. So in some ways, that was the problem I was trying to solve. I could see this problem, because I lived in both worlds.

Thus, Salima was struggling against two powerful organizational forces: the hospital system's need to be clinically productive with the university's need to educate students. As an AD, not only did she have to manage this tension between patient care and teaching, but she was required to help other faculty manage it as well. She saw both sides of the argument, living "in both worlds," but did not seem to have a good solution. Scott, on the other hand, was nonplused by "living in both worlds." He aimed to serve as a link between the many organizations of which he's a part. In fact, his in-between-ness had become a joke among his colleagues. He explained his role by saying,

> My allegiance always gets jokingly challenged by the folks at [the hospital system], and I would say I'm right on the line. …I don't know if "pride myself" is the right word, but I really strive to be the liaison, the primary link between the two making sure that the university always respects the viewpoints of [the hospital] both in the Dean's office and in my department role, and that [the hospital] respects the views of the University.

Scott's comment illustrates the liminal position of many ADs. Depending on the context in which they are working at that moment, they might be asked to represent the views of the academic department, the university, or the hospital system. The multiple organizational structures ADs have to navigate often require them to negotiate among the entities. Al described this scenario:

> It's a complex setting here…. There's the med school which, to some extent, represents education in these arguments. But to an almost larger extent, because there's much more money in this, is the research side of things, so the med school is not always necessarily just a "school." …second is the hospital, which is about seeing patients and also where all our residency programs are based, so they have a big education role themselves even though they're not the medical school. And then our faculty practice plan which is about seeing patients and paying physicians. There's this triumvirate of leaders across those three settings, and lots of things happen at that level, and then lots of things happen at much lower levels of trying to negotiate the super priorities.

Al's description illustrates the complex nature of the AMC organization, and the role of ADs within it. Each of the participants in the study had a unique way of managing these tensions and complexities. Scott enjoyed being the person in between the groups; Al saw it as a negotiation with winners and losers; while Kathleen relied upon her individual relationships to manage issues as they arise.

The ADs in this study discussed scenarios in which they were asked to advocate for education-related parts of their work and even create their own position descriptions. The competing values systems of the ADs and their multiple organizations also become an important part of the fortuitous nature of their roles.

How Context Shapes Roles and Values

The organizational context of AMCs is pivotal in understanding the experiences of ADs. Scott and colleagues (1998) structurational model of OID describes it as a process by which individuals utilize the structures of an organization as resources in constructing their identities. The organization (both overtly and covertly) can influence individuals' identifications by

enabling or constraining particular resources. So, in an AMC for example, hospital systems might discourage faculty from identifying as teachers by making the rewards for that practice unclear. While no one would say explicitly that education is not valued, the organization provides a clear structure (such as productivity data and benchmarks) for clinical care and no measures for educational efforts.

For ADs in this study, three extrinsic, contextual themes and two intrinsic, contextual themes appeared to shape their roles and values. Extrinsic factors were identified as such, if they were under the control of the organization, existing outside the AD. The extrinsic contextual themes are: 1) the organization's values, 2) reporting structure, and 3) organizational structure. Intrinsic themes were focused on concepts that were the perceptions of the ADs about themselves and their experiences. The intrinsic contextual themes are 1) the individual values of the ADs, and 2) how ADs define their colleagues. Examples are presented below for both types of themes, illustrating how the context of the AMC shapes the roles and values of the ADs.

Extrinsic factors that shape roles and values.

Organizational values.

First, the values of the organization, both spoken and unspoken, seemed to impact the way in which ADs in this study connected to their multiple identifications. For some participants, the funding structure of education illustrated organizational values, and shaped their perceptions. In fact, four of the individuals (Al, John, Mitch, and Salima) explained that they did not have access to or understand the funding structure of the education mission of the school. Using phrases such as "I am not privy to just about anything economic;" "someone through some sort of complicated formula;" and "it's very nebulous about how you can divide those funds," Mitch was "fine" with not having access to the funding structure. Part of his comfort level with

this lack of transparency could be related to his position in his institution. In addition to being a full professor, Mitch was the only individual within his institution qualified to teach certain sections of the course he directs. So, unlike some of the other participants in this study, Mitch did not seem to have to worry about the finances of his role. Salima had a better understanding of her institution's funding approach for education, but felt uncertainty about the amount of funding and how her effort is compensated. She stated,

> So, what ends up happening is everybody does an effort report about how much teaching they have done, and there is a certain amount of dollars in the pool. It depends on what effort report people file, and it all gets divided up. And then that money is handed back to the individual faculty at year-end. The problem is that there is no guarantee around the money. It is always at risk because you never know how much is in the pool, and you never know what number that is being divided by.

In addition to this lack of clarity about the size of the pool and number of faculty in it, Salima told a story about her percent effort after her first two years on the faculty. Her time was funded on an educational grant for those two years. As the grant came to an end, she discovered that her department had not budgeted to cover the remainder of her salary, so she was "pretty much at risk of getting paid 75%." Not wanting to take a pay cut or take on more clinical duties, Salima opted to go to the dean of education in her institution to ask for a special project to cover her unfunded 25%. This story illustrates how the complicated funding structure of medical education preserves the AMC's corporate value of clinical productivity (and thus revenue) (Deetz, 1992).

Assessment and evaluation was another framework participants used to discuss the values of AMCs. Six of the participants agreed that what is measured (clinical productivity) is valued within their organizations, and the lack of educational measures makes it difficult to advocate for educational work. Scott offered a laundry list of questions associated with how to measure education effort for his faculty: "What is education's role? How does it fit in? …How do you

quantify [faculty members'] productivity? And, how does their value feed back into the value of the system as a whole?" John seemed to have a fatalistic attitude about his work: "I could get international awards for being the world's greatest teacher. Doesn't matter. All that matters is did you meet your performance for productivity in the clinic."

It is important to note that these ADs and the faculty in their courses/clerkships are not penalized by their organizations for taking on educational work. Rather, the structures of the system provide context for how to prioritize their work. Four of the participants mentioned that they received a pictorial description of their productivity from their hospital system, often called a "clinical dashboard." These are commonplace in many AMCs today (Balser, Marx, & Manning, 2012). According to the participants in this study, dashboards seemed to provide positive social pressure to encourage physicians to meet their clinical benchmarks. Salima described what her dashboard looks like:

> We get a lot of information back, all kinds of information back, regarding our clinical practice. We have standards regarding needing to have certain panel sizes of patients, time spent in clinic, number of patients, RVUs [Relative Value Units] generated. So there is whole bunch of different data that we get back. It comes back to you on target, yellow zone, red zone. I think a lot of it is that we are left up to ourselves to keep our data out of the yellow or red zone.

These dashboards and structures of evaluation provide important information for ADs about the values of their health system.

Reporting structure.

The second extrinsic contextual factor that shapes the values and role of ADs is reporting structure. Six participants (Al, Faith, Kathleen, Levi, Mitch, and Salima) explained that they have multiple supervisors, and sometimes, it is unclear who should ultimately evaluate their work. Al, who directs both a course and a residency program, described of his supervisory structure:

> There's a lot of sort of matrix style reporting in any medical school. Though, for sure my main boss is my chair, certainly for anything related to clinical work and just sort of general administrative stuff.… On the med school side, our course is one of many, many, many courses, and we report to an overall second-year course director, and then to the associate dean for medical education, and the dean on up from there.

While most of the participants' responses sound similar to this one, two participants (Kathleen and Mitch) both agreed that their relationships with their deans of education were more collegial and less focused on supervision. As Kathleen illustrated, "it's not set up that I feel like she's the boss, per se. But, that's who I'm accountable to and who I present new ideas to and who comes to me if there are issues." When asked if the education deans provided any information related to their annual review, both Mitch and Kathleen said they did not. Two participants also described situations where they were required to justify their work to the individuals who supervised them. As Levi stated,

> In our department, we have a vice chair of education and also a program director. So I think on most issues I would report to her. But, I am getting more involved with reporting to the dean of educational affairs and the dean of student affairs. I think I have a working relationship with them, and the demands of the clerkship come from those individuals. …on top of that I also have the clinical point of view, for that I would report directly to the department chair.

The push to manage multiple supervisors and roles, thus multiple OIDs, appears to create extra work for ADs, leading to burnout and frustration. Alternatively, ADs might simply choose one target to focus on or shift from target to target (Ashforth & Johnson, 2001), thus attending to and valuing one area over another. For Salima, this reporting structure did require emotional labor. When asked how her division head (the person who does her annual review) feels about her education work, she said,

> I think that she's gradually maybe learning or understanding a little bit more about it. You know, there's always this question about whose responsibility is it to get her to know about it. Is it my responsibility to educate her on the academic part of my role?

Mitch also had a slightly disparate relationship with his chair related to his education responsibilities. He explained,

> With regard to my teaching in the medical school, [my chair] takes a completely hands-off attitude. I sit down with him once a year and go over the course evaluations, and he's very happy that the students like me, and he's very happy that I win teaching awards. But he does not offer any sort of advice, constructive criticism, anything like that because he's not in a position to do so. Most of the stuff that I do with regard to teaching, I'm pretty autonomous.

In these scenarios, the participants in the study appear to be disidentifying with their department chairs and discipline, and connecting more to the educational mission of the institution.

Organizational structure.

Five participants in the study told stories or described situations where the loosely-coupled collaboration structure of education work within the institution created a situation where they questioned their OID. In these situations, decisions were made associated with the courses directed by the ADs in the study, but the AD had little opportunity to contribute to that decision-making process. For example, Kathleen described a situation where her institution was considering significant changes to the curriculum, but not incorporating the feedback of ADs and core teachers. She stated,

> I just feel like there's a big disconnect with what we on the ground see and then what the heads of the school see. It's a very cordial relationship; I'm able to express this to them and convey the concerns of everyone who's on the ground with me, and they're receptive to it. But also at the same time they have their agenda they need to accomplish. That's been a major source of disconnect…

For Al's institution, the multiple tiers of responsibility related to education funding had a direct impact on his course, his department, and his role. He explained,

> There are certainly big decisions that happen at the med school level in terms of how departments are going to get recognized for their educational efforts. For example, the actually flow of dollars. That has a pretty significant impact on our department, and therefore has an impact on me as someone who is paid by the department. The more micro level stuff of what's going to be in a course and who is going to teach it, we have much more leeway over that.

Though Al was concerned about funding decisions and Kathleen's concern was over curriculum, the tenor of these comments is the same. Decisions are being made about ADs work at the institutional level, and the ADs in this study seem to feel as if they do not have a say in the process.

Intrinsic factors that shape roles and values.

In addition to the external contextual factors explained above that shape ADs roles and values, two intrinsic factors emerged in the data that seem to affect the OID of ADs. These intrinsic factors are 1) individual values of ADs and 2) how ADs define their colleagues.

Individual values of ADs.

Values are an integral part of OID (Ashforth et al., 2008; Cheney, 1983; Larson & Pepper, 2003; Russo, 1998; Scott et al., 1998). As Cheney (1983) contends, individuals draw upon both their personal values, as well as those espoused by their organization(s), to construct their OID. If the individual's values are in conflict with the organization, members of the organization may adopt, attempt to integrate, or reject the organization's values (Cheney, 1983).

As a way to uncover values and subsequent values conflicts in this study, ADs were asked to describe the parts of their work that they value most, and how that might be alike or different from the values of the organization. Six participants (Al, John, Levi, Mitch, Kathleen, and Scott) all mentioned the extent to which they still get an incredible amount of energy from providing excellent patient care in the clinical environment. Clearly still identified as a physician primarily, John explained his values as such, "Patient care is first. I couldn't imagine taking care of a patient and thinking, 'This is what I do on the side.' I just couldn't imagine doing that to a patient." Kathleen specifically cited the experience of working with learners in the clinic as the most valuable part of her job. In fact, she structured her clinic to maximize

those experiences. As she explained,

> I bond well with those patients, and those are the clinical encounters I like the best, so I strategically try to make my clinical life more and more [sub-specialty] oriented…That interface gives me a really good opportunity to work with students one-on-one, and that's very energizing.

In addition to the clear value of patient care, five participants (Al, Faith, John, Mitch, and Scott) expressed their value of collegiality, particularly in the academic medicine setting. As Al said,

> I really like the collegiality of being in an academic setting. That's not just within my institution but even nationally, being involved in organizations and going to annual meetings of educators and so on. There's a lot of recharging and new ideas and so on that come out of all of those settings.

Faith described a specific project she is working on with other educators at her institution. The project requires her to work very closely with her colleagues. She stated,

> The people that I'm working directly on that with I think are who I feel most connected with. …we're collaborating. We're working on a specific, a specific common goal. And we each have our defined roles, but we can still can cross over and help each other.

In both of these scenarios, the study participants clearly stated their value for collaborative work toward a common goal.

In addition to the value of collegiality, four ADs in the study (Al, Faith, Levi, and Scott) placed value on leaving a legacy and mentoring the next generation of physicians. Faith explained, "students reward us as they go on to choose really cool things, whether it be our field or not. Having our legacy through mentee is a very cool thing, and that is very rewarding." Levi on the other hand took particular pride in encouraging students to enter his specialty. He said,

> Encouraging careers in [my specialty] is one of the things that I track, and how many of our students actually choose [my discipline] as a career…. A lot of our students are biased about [my discipline] coming in, so seeing those light bulbs go off and seeing students change their whole careers after going through our clerkship is pretty rewarding.

Coupled together, the values of patient care, collegiality, and legacy show the ADs connection to relationships within the organization. Values are an important part of understanding OID. Some

participants' values seemed to contrast with those of the hospital systems. Krieiner and Ashforth (2004) discuss the notion of ambivalent identity. The authors contend, "given the complexity and equivocality of modern organizations and the loosely coupled values, goals, and beliefs of the typical individual, one can simultaneously identify and disidentify with one's organization (or aspects of it)" (p. 4). In the case of ADs, this study indicated that they might experience multiple ambivalent identities, in part because of the multiple organizational contexts with which they interface.

How ADs define their colleagues.

The final intrinsic theme that emerged was the definition and redefinition of colleagues for ADs in this study. Four ADs agreed that they often defined their social support network based on convenience or proximity, because of the pace of the environment and limited time available to make connections. As Al explained, "I can text message one of my colleagues and get a response in a minute versus a more deliberative process that might take place over a few days or weeks reaching out to national colleagues." John agreed, telling a story of how he connected with a close educational colleague:

> Because [my colleague] was down the hall I walked down the hall, poked my head into his office and asked, 'Who in your department would be best to do medical education for students?' He raised his hand and said, 'That would be me.' Frankly, had it not been for that set of circumstances I probably wouldn't have had that sort of relationship established.

When I asked who her closest colleagues are, Kathleen also stated, "The ones inside my university just because we're here and I see them quite often."

Despite their resourcefulness in creating a social support network of those around them, four participants described their education work as a sometimes lonely endeavor. Faith, for example, felt isolated because of the location of her clinic, "I have a big black hole here because of the physical location, and the campus set up. It is very spread out. …When I'm here, my peers

are often not physically here."

Alternatively, Kathleen felt fortunate that her institution created a structure for her peers to connect with one another. She explained,

> I don't think every school does this, but we have a clerkship block directors meeting twice a month. ...[a]ll of the block directors meet for every rotation in the medical school. And then once a month we have a sub-I directors meeting where all the fourth year directors meet, as well. So, that's a great place to disseminate information those from the school to us and then from us to each other.

As these examples illustrate, there exists a lack of formal structure for many ADs to form professional relationships and identifications. Though some institutions do provide a structure, the tensions among an ADs roles still ask them to negotiate their identities regularly.

Chapter Summary

This chapter provided an in-depth analysis of the themes that emerged from semi-structured interviews with eight ADs at AMCs. True to CGT methodology (Charmaz, 2006), three core categories were identified. The first core category, socialization, included themes of falling into the medical education role and ADs defining expectations for themselves. The second core category focused on the sense-making process ADs use to understand their multiple targets of OID. This category was comprised of themes such as managing multiple perspectives, learning to fight for support, and finding a home. The final core category in the theme analysis describes how the organizational context shapes ADs values and roles. In this theme, both extrinsic and intrinsic contextual factors appear to have an influence on values and roles. Extrinsic factors included the organization's structures and its enacted values. Intrinsic factors were the ADs' connections to patient care, wanting to leave a legacy, and defining their tribe or group of colleagues for their work. As AMCs become increasingly more complex, providing

ADs with a framework for understanding how to manage multiple targets of OID might be helpful, increasing their satisfaction and vitality as faculty members and physicians.

Chapter 6: Constructivist Grounded Theory and Conclusions

The interviews conducted for this study provide insight into the relationships between ADs and their organizations. True to CGT, the theory presented here is interpretive in nature. That is, it seeks to illuminate patterns and connections among the stories of the participants, rather than to offer causal relationships. According to Charmaz (2006), this type of theory "assumes emergent, multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual" (p. 126). This type of theory is particularly appropriate when exploring OID, since it, too, focuses on process and social construction.

A Grounded Theory of ADs OID

The theory presented subsequently is constructivist, in that it is one interpretation of the experiences of the ADs in this study. I sought to focus on how and why the participants made sense of their connections to their multiple targets of OID. The goal of this approach was to uncover the extent to which ADs experiences were embedded in the larger (and sometimes hidden) networks and hierarchies of AMCs. Subsequently, I was alert to the communicative strategies and approaches the participants used to negotiate their OID processes. I acknowledge that the theory developed in this study "is contextually situated within the time, place, culture, and situation" (Charmaz, 2006, p. 131) of this study. Figure 6.1 provides a framework for understanding the theoretical constructions that emerged in the data.

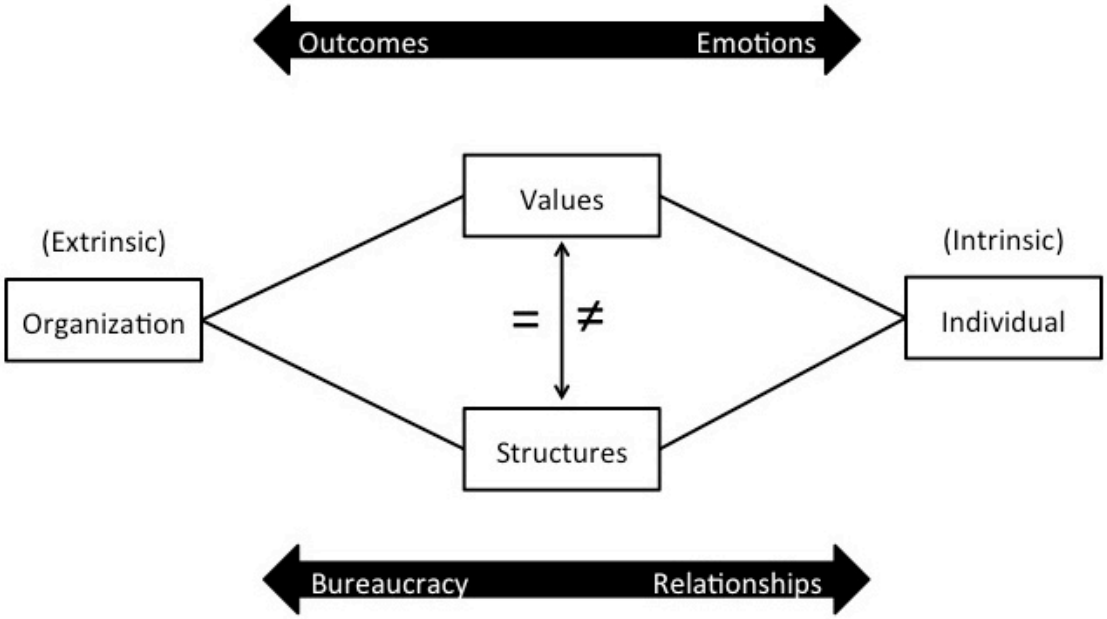

Figure 6.1. ADs in this study experienced multiple tensions in managing their OIDs. They connected to their organizations (or targets) of OIDs via values and structures, which informed and shaped one another.

The organization and the individual.

First, the constructs of the organization and the individual are connected via values and structures. In this study, the term organization represents different things to different individuals at different times. For example, sometimes the target organization is the university, representing values of tradition and bureaucracy. Other times, the target organization might be less defined, such as the group of individuals within the university who consider themselves medical educators. This perspective furthers the work of MacDougall and Drummond (2005) and Taylor and colleagues (2007) who have argued that medical faculty members often see themselves first as clinicians or researchers. Therefore, their primary responsibility is patient care or research, not education. In their study of clinician educators (faculty who teach but perhaps do not have leadership roles in education), Kumar, Roberts, and Thistlethwaite (2011) found that "teaching in itself is not perceived as a definitive career pathway, but, rather, as an activity that any doctor

can engage in while undertaking clinical duties or research" (p. 501). Regardless of the specific definition, ADs in my study connected (or attached) to their targets of identification (or organizations), via the organization's values and structures (as illustrated in the third core category, *how context shapes roles and values*).

For example, Salima's conception of her values in relationship to those of the institution(s) was defined by the way in which those values were prioritized and enacted. That is to say, her definition of values was shaped by the institution's definition. This sentiment was illustrated by the following comment:

> I think one of the challenges is that nobody just has one value. People have multiple values, and I think that's the same for individuals as it is for institutions. It's not necessarily about like, "I have these values, and they have those values, and they completely don't match." My values are the same, but the problem becomes more at the prioritization of those or the way those are played out.

In other words, it was not the values, themselves, but the way in which the values were enacted that shaped her OID. The values and structures of the organization sometimes align (as indicated by the = sign) and other times do not align (as indicated by the ≠ sign). For years, scholars have lamented the effects of structural changes in academic medicine on the educational mission (Bloom, 1988; DeAngelis, 2004; Korn, 1996; Ludmerer, 1999). These scholars contend that, by relying on the clinical and research missions to support education in American medical schools, a system has been created where education will never receive the level of attention it deserves. Kumar and colleagues (2011) found that the emphasis on research and patient care in academic medicine can create feelings of marginalization and a decrease in credibility for faculty who choose a career path focused on education. Considering this context, it is no wonder that the faculty in my study preferred to say that they "fell into" their roles as academic directors. Admitting they pursued this work is essentially saying that they are committing to a career in which the fight for support is constant. Yet, as the participants in this study grew into their

positions, they were legitimated by receiving a title (course director, vice chair, program director, or clerkship director) and dedicated time to support their work.

The double-sided arrow represents the constant negotiation that ADs feel to manage these values and structures. Al described the negotiation process like this:

> I would love for all my educators to have more time carved out to do education. That being said, the down side to that is then there's less revenue for our department. There's then less money for us to do other things. That's always going to be a tension. And I think my role is to advocate for people having an appropriate amount of time for education, but also be reasonable on recognizing that there are other missions and we have to fund our department.

Certainly, the role of faculty in academic medicine today requires a level of advocacy not experienced by previous generations (Pololi et al., 2009). Bloom (1988) and DeAngelis (2004) have criticized this shift in the role of the academic physician, arguing that they spend more time managing the trivia of their organizations, than healing and educating future physicians. This is confirmed by Deetz (1992), who contends that most of the work of professionals in postmodern organizations today is focused upon the production and management of their identities. Tracy and Trethewey (2005) further this argument, explaining that employees "come to understand themselves through overlapping identifications with multiple organizations and professions" (p. 172).

As Kreiner and Ashforth (2004) explain, "given the complexity and equivocality of modern organizations and the loosely coupled values, goals, and beliefs of the typical individual, one can simultaneously identify and disidentify with one's organization (or aspects of it)" (p. 4). In the scenario described above, ADs must manage the needs of medical students with the needs of patient care. Understandably, the participants in this study choose patient care if the need is urgent, but the constant re-prioritizing requires ADs to "use valuable cognitive and emotional resources that could otherwise be spent on organizationally helpful pursuits" (Kreiner &

Ashforth, 2004, p. 4).

Connecting outcomes with bureaucracy.

Often in the study, the participants associated the organization with a focus on outcomes or bureaucracy, as illustrated in Figure 6.1. It is important to note that this connotation was not always a negative one. For example, Faith, Kathleen, and Salima all discussed how a clearer measurement system for their educational work might be helpful to them in the promotion and tenure process, as well as in their abilities to communicate the value of their work to their colleagues, department chairs, and deans. Faith explained how she would use such a tool:

> I think having an educational dashboard actually does help, in that I could see myself compared to my peers. So I could look on a graph and see that I'm teaching more than x, y, and z in the department, but not as much in residency, because that's where my hat is. I could see who the high teachers and the low teachers are. I could look at it and not necessarily be sad about the low teachers, but as an opportunity: "Hey, do you guys want to teach more?" You know, from management standpoint of the educational course.

The structural tensions faced by the ADs in this study further solidify AMCs as postmodern organizational systems. Mumby (1987) contends that organizational structure is "an integral part of the dispersion of power in organizations" (p. 116). Building on the work of Ranson, Hinings, and Greenwood (1980), Mumby (1987) explains,

> If we view organizations as being made up of different and competing values and belief systems that embody the interests of different groups, then the groups with the most power will be those that are best able to integrate their sectional claims into the very structuring of the organization (p. 116).

Academic medical centers seem to have institutionalized the structures of clinical care, while offering less structure around medical education, specifically for faculty members in AD roles. For example, it is clear to the participants in this study how to meet the expectations of the hospital system: one sees patients, effectively and efficiently. But, the structures of the education role are less clear.

Connecting emotions with relationships.

Alternatively, the ADs in the study often used emotions and connection to others to describe their own values. This created tensions for the participants, for example, between the organization's need for productivity and revenue, and the participants' need to encourage clinical teaching among their colleagues. Kathleen explained how she relies on developing interpersonal relationships to encourage teaching among her colleagues. For example, She stated, "…our biggest struggle with scheduling is getting people to have the whole afternoon free. So I have gotten a retired physician to really love that role."

A value of collaboration creates another paradox for ADs, placing them in between two parts of their organizations and two targets of their identities. On one hand, the traditional academic value of the independent scientist (Cooke et al., 2010; Pololi et al., 2009; Trowler & Knight, 1999) still pervades AMCs. So, while these projects may require collaboration, many universities still place a high value on single-authored studies and primary investigator (PI) status on grants. While many institutions are encouraging a team science approach to scientific discovery (Cooke et al., 2010), individual authorship is still highly prized. On the other hand, medical schools are encouraging interprofessional education and team-based care (Cooke et al., 2010), while hospital systems are increasing productivity requirements (Balser et al., 2012). While these tensions may exist for many faculty in higher education today, the pull between the individual and the collective seems to be amplified for ADs, possibly because of their roles within the institution.

Values and structures.

Finally, the connection between values and structures is an important relationship that developed emerged within these interviews. At times, the ADs in the study discussed situations

in which the values of the organization shaped the organizational structures, such as the precise measurement of clinical productivity. Consider Kathleen's comments around the competition between clinical work and education:

> We get these little pie charts, and they show us how much money we're bringing in and what our perspective earning potential is for the year; what our salary is and how much tax we have to pay to the department. I think everybody really focuses on that. And if somebody says, "In six weeks I want to do a small group session with the students. Block out my clinic." I don't think anyone in an authoritative role would give them a hard time about it. But I think when it comes to personally looking at your sheet and being like, "Wow, am I earning my salary? Am I going to be able to get a good review at the end of the year because of my clinical income?" I think that's where people are like, "I can't cancel out my clinic to do this educational activity."

While the decision to teach was ultimately left up to the faculty member at Kathleen's institution, the bureaucratic conventions of clinical care (such as the RVUs and productivity reports) deincentivized the teaching role of faculty. The value was placed on the activities that could be easily measured and earn revenue for the system. These scenarios are an example of Clair's (1994) self-contained opposite. AMCs are not actively discouraging educational work. Rather, the structures of the organization are encouraging faculty members to devalue it. As Clair (1994) explains, "at times, subjugated individuals actively participated in the discursive practices that sustain and intensify their own oppression" (p. 238). By choosing clinical care over education, these faculty maintained the bureaucratic values of the AMC.

Other times in the study, participants described how the structures informed values. For example, since medical education is seen as an institutional responsibility rather than a departmental one, administrative support of education is perceived by some participants as a responsibility of the dean's office, rather than the academic departments. When I asked Kathleen about the level of support provided by the medical school for her education efforts, she said,

> I'm very lucky, I have a full-time person, that's my administrator, but my department supports that, not the institution, directly. I mean I'm sure the institution provides money to our department, but … as far as I know, there's no provision from the school for

> administrative support of our individual clerkship. If I need something, I have to go to the associate dean and say, "Hey, I need someone to help me organize this," and they might be able to find administrative support for me, but it's really on the department level.

This was a sentiment of other participants as well; the structure and funding of medical education in the U.S. creates a situation where the curriculum is owned at the school level, rather than the department level. This structure inherently creates a values conflict for ADs. Russo (1998) contends that, because the organization provides the context within which local identities may flourish, the organization is often seen as a "home" or "vehicle" for expressing OID (p. 102). But, in the case of ADs, they might be encouraged to focus their OID on other targets such as the education mission within their institution or their disciplinary society, as opposed to their department home. In addition to these challenges with reporting structure, the organizational structure of AMCs may confound their struggle to find a home, asking themselves, "do I ally with my department or with the school?" Rather than an either-or proposition, the ADs seem to treat it as a continuum, constantly moving between the two values sets and OID targets.

In this scenario, Ashforth and Johnson's (2001) research on identity salience is a helpful lens. The authors contend that salience is "the probability that a given identity will be invoked and multiple identities can be ranked in a 'salience hierarchy' according to their relative salience" (Ashforth & Johnson, 2001, p. 32). Organizational members tend to move, relatively seamlessly, between identities within their organization (such as committee or department membership), as well as between those situated outside their organization (such as profession or discipline). Individuals may identify and disidentify regularly, and conflicts among targets of identification (such the medical school versus the hospital system) may facilitate shifts in salience. So, "just as a person can argue with a spouse about specific issues and yet retain an abiding love for him or her," ADs can simultaneously connect and disconnect with parts of their

organization (Ashforth & Johnson, 2001, p. 43).

The overall image of the theory in Figure 6.1 is constructed as a continuum to illustrate the processual nature of OID. As the individuals in the study have different experiences or as the context of their multiple organizations change, the connections between these elements of the OID process change as well.

Connections to the Literature

As the number of potential targets of OID grows in higher education and the identities of faculty are increasingly segmented, it is imperative that we understand the process by which faculty manage their identities. This study offers a snapshot of those processes for one segment of faculty, ADs in AMCs. This section connects those results to the literature in three main areas: a) role balance, b) the right people, with the right resources, and c) clearer structures.

Balancing role clarity and ambiguity.

This study provides three important outcomes related to the role of ADs and organizational identification in medical education. First, the findings suggest that providing more explicit socialization to faculty members who choose medical education, and more specifically the role of a clerkship or course director, as a career path could lead to improved experiences for faculty and students. Trowler and Knight's (1999) perspective about faculty socialization in post-modern higher education institutions is especially relevant to this discussion. ADs must be seen as active agents in their own socialization, "having the potential to actively seek out the information they need or to develop strategies for coping with uncertainty" (Trowler & Knight, 1999, p. 185). Explicit structures such as mentoring or job training from veteran ADs and a clear cohort of colleagues could provide ADs with a better understanding of the structures that might shape their courses and roles. One participant in this study, Scott,

believed this is a crucial part of training the next generation of educational leaders. He explained,

> Part of training leaders is about empowering everyone and anyone I come in contact with. …I meet with a lot of people across faculty, residents, and medical students on a regular basis just for that...to mentor and to try to empower them. My thought is the way you train these skill sets is, 1) you have to have someone who is going to mentor and empower them and point them out specifically. I think oftentimes mentorship it too vague. Then, 2) I think you have to be in difficult or challenging situations that really highlight the traits.

As Scott indicated, these skills and attitudinal factors that lead to success are not yet clearly defined.

However, it is important to note, here, that some role ambiguity seems to be important to ADs, particularly since many academic physicians feel confined by the structure and top-down management of the clinical side of their work (Swick, 1998; Oveseiko & Buchan, 2012). In this study, Al, Kathleen, Mitch, Salima, and Scott, in particular, seemed to benefit from the ability to define the scope of their roles. This definitional process allowed them the opportunity to take on projects of personal importance to them, while still fulfilling an important function within the institution. By providing a loose structure for the AD role and facilitating a sense of community among ADs, AMCs could provide a framework that benefits both the institution and the individual.

Second, with involvement in role definition and explicit socialization, ADs would be more likely to begin work immediately, eliminating important gaps in organizational learning for new ADs (Trowler & Knight, 1999). During this time, ADs will need a space to discuss the multiple, embedded contexts in which they might be working (Trowler & Knight, 1999). While ADs will have already served as physician educators, the role of a clerkship or course director will require a deeper level of understanding of the multiple organizations in which they will work. A greater sense of involvement in the role definition process and clearer socialization

could decrease feelings of isolation experienced by medical educators (Kumar et al, 2011). Academic directors could benefit from an onboarding period in which they work with a mentor to define their goals and measures for success in their roles, as opposed to a standardized position description. This intentionality would allow each AD to situate their role contextually within the institution and perhaps develop common goals across academic disciplines.

Third, regardless of their institution or discipline, ADs share the common goal of being legitimized and valuable contributors to the mission of the institution. Having a specific description of responsibilities for ADs might encourage young faculty members to pursue the role of AD as a career, rather than falling into it, as many of the individuals in this study described. Having a clearer pipeline for ADs, as well as providing expectations and socialization, would help to further legitimate this role as an important part of the medical education workforce.

The right people, with the right resources.

The data from this study also indicate that certain strengths and skills may serve ADs well, while other affinities or personality traits might make the OID process more difficult. Ashforth and colleagues (2008) contend that the process of sensemaking "captures the turbulent, intense moments during which individuals are engaged in identity work as well as how individuals create continuity" (p. 345). Because ADs are often asked to move between organizations or targets of OID, the process of identity work is constant. Some individuals may have more integrated or holistic identities, making movement between them easier. Organizational context might also make the OID process easier. The more integration between the university and the hospital system, for example, the easier it might be for faculty members to move among their identifications (Ovseiko & Buchan, 2012).

Larson and Pepper (2003) offer insights into the specific ways that employees communicatively cope with competing targets or sources of identification. These authors contend that some individuals compare and contrast their options, rely on premise-based logic to manage the conflicts, or evaluate their options in relationship to others within the organization. While some employees in Larson and Pepper's (2003) study did this with ease, others struggled to make sense of this process. ADs seem to have the same challenges. Thus, it might be helpful to screen AD candidates based on their ability to negotiate these identification demands. Alternatively, it might be helpful to share this process with ADs. As Larson and Pepper (2003) explain, "having people talk about their identifications may help them to work through those tensions" (p. 553).

Realistically, changing the culture of both the hospital system and the medical school to provide more congruous roles for ADs is challenging. In fact, over two decades ago, Bloom (1998) argued,

> The most pressing question for medical educators today is whether, in current programs of change, the efforts to adapt to the real conditions of modern medicine *will address the structural problems of organization, the sources of authority and allocation of resources, the power centers of decision making* (p. 299, emphasis in original)

The pace and scope of change in academic medicine has not decreased; in fact, with healthcare reform in the U.S., some maintain that more significant change is to come (Cooke et al., 2010; DeAngelis, 2004; Pricewaterhouse Coopers, 2012; Ramanujam & Rousseau, 2006; Swick, 1998). Based on the experiences of the participants in this study, it appears that those who are most likely to succeed in the AD role are not only comfortable with the multiple targets of OID, but also find satisfaction and individual agency in serving as an advocate (whether that may be for their discipline, their hospital system, the educators in their department, or themselves). Scott, in particular, enjoyed his work as a connector:

> My allegiance always gets jokingly challenged by the folks at [the hospital system], and I would say I'm right on the line. …I don't know if "pride myself" is the right word, but I really strive to be the liaison, the primary link between the two making sure that the university always respects the viewpoints of [the hospital] both in the Dean's office and in my department role, and that [the hospital] respects the views of the University.

Deetz (1992) contends that, in postmodern organizations, most of the work of professionals is focused on managing and advocating for identities. Therefore, placing individuals AD positions who already feel comfortable serving as advocates and liaisons between the groups and organizations within AMCs may allow those individuals to expend energy on other important tasks.

Clearer structures.

The third set of findings focuses on clarifying a number of structures for ADs. An area of opportunity that emerged in the data is that many ADs work in a matrix-style reporting structure, which is to say that they may have more than one individual who supervises and/or evaluates their work. In addition to their department chair, some ADs have a division director (in large departments with multiple units) to whom they report. Academic directors may also report to a dean or vice dean of education for responsibilities related to their clerkship or course. An associate dean of undergraduate medical education may be responsible for providing feedback on the work associated with their course/clerkship. Finally, they might have a service line leader or hospital administrator that may direct their clinical work. While it is likely not possible to simply eliminate any of these sub-organizations, it may be viable to develop a clearer path for the other individuals involved in an AD's work to provide feedback or contribute to an annual review. For example, the ADs multiple supervisors could fill out a modified 360° evaluation form, that is then provided to their department chair each year for their annual review.

The complex organizational structure of academic medicine (and AMCs specifically) provides additional, helpful context to understand how ADs make sense of their roles and values.

AMCs, by nature, often have paradoxical elements of their structure. As Stohl and Cheney (2001) explain, while some organizations try to espouse values of active participation (for example, AMCs have committees and shared governance structures), the organization still hangs onto bureaucratic and hierarchical structures that limit members' participation in decision-making (such as the value of productivity measures within an AMC). The authors contend, "[t]his leads to the paradoxical situation wherein actors try to formalize a process that at its very heart needs to be informal and adaptive to changing situations" (Stohl & Cheney, 2001, p. 326). This paradox emerged in the data in two areas: the loosely-coupled collaborative structure of AMCs and the AD's lack of understanding regarding decision-making around education. This situation illustrates Stohl and Cheney's (2001) paradox of participation. The medical school needs ADs to do the work of education, but decisions are often made without their consult regarding the role of their courses or clerkships within the larger structure of the curriculum or institution.

Additionally, participants in the study indicated that they were often required to explain the work of medical education to their department chairs. In speaking to a group of educational leaders in medical schools, Kumar and colleagues (2011) found that participants often did not come into their ranks by achieving primary success in educational endeavors. Rather, "it was common for participants to progress to senior positions by achieving academic status in a clinical discipline or in research and then to become involved in teaching" (p. 500). Thus, more training and engagement of department chairs and division directors where appropriate, at the school level on curricular issues could address some of these concerns, while simultaneously legitimating the work of medical educators in this role.

As faculty members become ADs, they often face the challenge of having to go up for

promotion and/or tenure in a system that is not structured to support the type of scholarly practice common among ADs. Certainly, it can be difficult to position medical education research and the scholarship of teaching and learning within a framework that values more conventional academic goals such as single-authorship and publishing in high impact journals.

Further, the type and paucity of information available to ADs to present a case for their educational administrative work creates a barrier for them in the promotion and tenure process. The individuals in this study indicated that an eRVU (or educational Relative Value Unit) system would not necessarily solve this problem. However, the participants agreed that having some measure of their work beyond student evaluations of teaching would be helpful. Medical schools could benefit from exploring and developing ways to count and reward the work of ADs outside the current structures. For example, Salima attempted to get a measurement system started at her institution. But, the program is at risk of being cut. When asked why, Salima explained,

> I think it's partially because it's going to take me a little bit of time here to do this, and I worked to buy out a tiny bit of my FTE, like .05. And I think it is a question of how valued is this within our system right now? My sense is it's not as a high value, so I think it's at risk. I have had conversations about this at the medical school level, like "Why are we leaving this up to the departments to make the decision about whether they want to support us or not?" And is there a way the medical school could be more proactive in supporting the educational mission, at least for undergraduate medical education?

A small investment in a program such as this could yield important rewards in terms of retention and satisfaction for ADs.

The data from this study indicated one more structural element that would be important to maintain the vitality of ADs. The participants agreed that it was important to preserve opportunities for meaningful collaboration among educators. Some participants indicated that they were motivated by the notion of giving back or leaving a legacy, while others derived energy from working with other teachers to accomplish a task or educational project. The findings suggest that an important part of OID for ADs is their connection to relationships, with

colleagues and learners. Kumar and colleagues (2011) findings support this perspective as well. Unfortunately, it was clear that the participants in this study did not always feel as if the structures were in place to support this type of collaborative experience. For example, Salima described her experience of being at a medical education conference:

> For you to be in a place where you're valued, and people know the work that you've done, I think that was also a very helpful place to be. Just to be able to be comfortable enough to share that information and to have those relationships and those groups has been very helpful. For me, a lot of it is just not feeling alone.

Academic medical centers have an opportunity to acknowledge the values important to ADs. The structures they describe (such as a yearly retreat or attendance at national education meetings) are cost-effective ways to keep ADs firmly identified with both the institution and their important educational work.

The three themes above, a) role clarity, b) the right people with the right resources, and c) clearer structures, provide important context to consider the findings of this study. It is important to note that the suggestions for improving the experiences of ADs are presented as opportunities both for the individuals within the role, as well as the organizations they serve. Too often, faculty developers rely upon a model whereby they seek to fix the individual faculty member, rather than to understand and change the organizational policies and programs that reify the power structures in place. By closely examining the stories provided by the participants in this study, I sought to uncover some of the implicit values and power dynamics at play in today's complex AMCs.

Limitations of the Study

Several limitations are worth noting in this study. First, I chose four institutions for this study, based on their similar size and geographic diversity. As such, some experiences may be shaped by the type of institutions chosen. Once I chose institutions, participants were solicited

using a purposeful snowball sampling strategy. Since individuals often connect with similar individuals, some voices may not be represented in the group. Second, given the use of qualitative methods, findings from this study may not be generalizable to the experiences of all clerkship and course directors in academic medical centers. However, since the goal of this study was to uncover a process, I am confident that the experiences presented here do offer unique insights into the organizational experiences of ADs in the U.S. Third, only one, 90-minute interview was conducted with each participant. Extended or second interviews could have allowed for participants to share additional stories or clarify their feelings about their experiences. Lastly, although I assured my participants anonymity, some may not have been comfortable disclosing certain information with me. At the same time, the candor of the stories led me to believe that most or all participants felt comfortable with the process.

Suggestions for Future Research

Taken as a whole, the findings in this study offer several important opportunities for future scholarship in organizational identification in higher education, faculty development, and medical education. First, this study is the first of its kind to explicitly examine the pathways to and socialization process for ADs. In fact, faculty orientation and socialization in medical schools is widely understudied (Blackburn & Fox, 1978; Kumar et al., 2011). As illustrated by Schuster and Pangaro's (2010) structural explanation of leadership careers in medical education, many rank-and-file AMC faculty teach; but, a much smaller subset make up the leadership of medical education in the U.S. Traditionally, academic directors have been asked to learn on the job (Schuster & Pangaro, 2010). This study's findings were consistent with those of Kumar and colleagues (2011) who contend, "most socialization and support practices in academic medicine were informal and often occurred in the context of people's social and professional networks" (p.

501).

Considering the unprecedented change and complexity in AMCs today, the success of faculty may depend on their ability to understand the organizational culture and tacit knowledge required. Further research is required to explore best practices in programming and understand the connections between recruiting, onboarding, retention, and success (Pololi et al., 2009). The literature suggests that role models and mentors play an important role in socializing and supporting new faculty in academic medicine (Pololi et al., 2009). Additional research into the mentoring structures for ADs may help faculty developers and medical school administrators to provide more extensive support.

The measurement and reward process of ADs' work is second opportunity for inquiry. A number of studies have explored the reward systems for clinician educators (Bland & Holloway, 1995; Bligh & Brice, 2009; Ephgrave et al., 2010; Kumar et al., 2011; Levinson et al., 1998). Since ADs' roles are even more divided among different tasks and organizations than clinician educators, their promotion and tenure process is fraught with challenges. For example, when I asked Salima about her last annual review and what her division head thought about her education work, she said:

> Probably the best way to explain it is that she is probably doesn't know a lot about it. I think bits and pieces she does. She does kind of know that it's paying 50% of my salary that she's not paying.

As Salima indicated, more work is needed to develop structures and pathways for ADs, so they have a clearer path to administrative support, promotion, and tenure. Further, it might be helpful to learn from those institutions that have developed a more accurate way to measure the work of ADs, and to what extent those strategies have or have not been useful in the annual review and promotion process.

A third opportunity for future research is in the relationship between OID and context.

This study provides a conceptual framework to understand the OID process of ADs in AMCs. Since identification is a processual activity, shaped by context (Scott et al., 1998), exploring the identification of university faculty in multiple settings may serve to expose subtle differences for identification management used in different contexts for faculty with different roles. Identification is a compelling construct because "it roots the individual in the organization. …research indicates that identification addresses various self-related needs" (Ashforth et al., 2008, p. 359). Opportunities exist for organizational and higher education scholars to further explore how these relationships are perceived as mutually beneficial and to what end. The results of this study indicated that ADs do value their sense of identification with multiple targets including medical education colleagues, disciplinary connections, the medical school, and the hospital system. In the same vein, it would be helpful to have a better understanding of the connections among the multiple identifications ADs manage. As Ashforth and colleagues (2008) maintain, "given the positive correlations among multiple identifications, we encourage researchers to develop more parsimonious models of identification that incorporate multiple loci" (p. 360). This research is important because ADs often do not have the opportunity to reflect on these issues. For example, when I asked Kathleen if she had anything she wanted to share at the end of her interview, she stated,

> I appreciate you doing this kind of work and having the opportunity to talk about this because every day things come up where you get frustrated, and you're like, "Oh, well this just another battle to fight or another thing to organize." Then when you get an opportunity like this to talk about things and you reflect on the big picture, you realize that things are pretty good.

Finally, the structures of academic medicine organizations became an important lens through which to view the experiences of the participants in this study. Whether it was the finances of medical education, the relationship between the academic department and the dean's office, or the reward system and values, ADs have a unique perspective on the organization of

medical education in the U.S. Healthcare reform and advances in technology continue to exert pressure on AMCs to change and adapt. ADs are often asked to play an intermediary role between two groups of people or areas of the organization. This type of experience could be helpful in planning and research on the structure of the future of medical education.

Conclusion

The purpose of this study was to explore the OIDs of ADs in AMCs. Eight, in-depth interviews with ADs from four similar institutions were conducted to understand how they manage the multiple values and priorities of their roles. The study sought to answer three interrelated research questions: 1) how faculty become ADs; 2) how they make sense of their roles and values in relationship to those of the institution; and 3) how the structure of AMCs shapes the roles and values of ADs. The interviews were taped, transcribed, and coded for core concepts and themes, true to constructivist grounded theory methodology (Charmaz, 2003). Using dendritic crystallization (Ellingson, 2009), an additional narrative analysis was conducted to further examine the experiences of the participants within context. These analyses revealed important connections between faculty socialization, organizational structures, as well as individual and organizational values.

Since AMCs are complex, bureaucratic organizations with multiple, interconnected missions and constituencies, ADs play an important role in liaising among the missions of patient care and medical education. These individuals are responsible for developing faculty, as well as managing curriculum and assessment. However, AD roles often lack clear position descriptions and face economic pressures to spend more time in clinical duties at the expense of their education responsibilities. These conflicts in OID can lead to dissatisfaction and an unclear path to tenure, promotion, and rewards.

Findings from this study indicate that ADs are critical to the education mission and can be powerful in shaping the institution. The diverse responsibilities of ADs might create isolation and mean that their paths to promotion are ambiguous or tenuous. As Faith explained,

> It often feels like a lonely field where you're doing your work, but you don't know you have others around you doing the same work. …I think it's more acknowledging as opposed to causing negative feelings. I think just about all the educators would feel the same way. Instead of, "I feel like I'm the only one doing these things," in fact there are a bunch of us all over the nation doing these things.

Results of the study can be used to shape policies and faculty development efforts for ADs, leading to a clearer sense of purpose and reward system. A deeper understanding of the experiences of ADs benefits both faculty and institutions. Faculty receive more role clarity and individual agency, and AMCs receive information on how to better meet the needs of this population, thus improving the efficacy of medical education.

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Appendix A: Semi-structured Interview Protocol

First, I'd like to ask you a few questions about your role as [residency/clerkship/program director].

1. Tell me more about your job.
    a. What are your responsibilities? What is a typical day like?
2. How is your position structured?
    a. To whom are you accountable? Who is your "boss?"
    b. How is your time divided between your areas of responsibility?
    c. How has your position evolved over time? How have your responsibilities changed?
3. How does this structure work for you? Would you like to see anything changed?

Next, I'd like to ask you a few questions about what you like and don't like about your job.

4. What do you like most about your role? What parts of your work give you the most energy? What parts of your role are most challenging?
5. What parts of your job do you value most? How does this compare or contrast with your academic unit? With your hospital system?
6. What parts of your job are you rewarded for?

Now, let's talk about your training as a [residency director, clerkship director, program director].

7. When did you become a [residency/clerkship/program director]. How did you learn what was expected of you in your role?
8. Who did you go to for advice? Has that changed over time? If so, how?

Next, I'd like to explore your professional relationships and support networks.

9. Who are your peers within your institution?
    a. Who do you rely on to share ideas, get feedback, and consider changes?
    b. How would you compare your relationships with your colleagues at your university with those outside?

Lastly, I'd like to ask about your relationship to the university and the hospital system.

10. How does your academic unit support you in your role? How does your hospital system support you?
11. What parts of your job are most important to you? Is that similar or different to the value assigned by your academic unit? By your hospital system?

Thank you so much for your participation. We're about ready to wrap up.

12. After reflecting on your experiences, is there something else you would like to add?
13. Is there anything you would like to ask me?

Appendix B: Email Invitation to Participants

Listserv Message: By Chance or By Design

SUBJECT LINE: Your help needed for Research Study on Course and Clerkship Directors

My name is Krista Hoffmann-Longtin, and I am a doctoral candidate in the higher education and student affairs program at Indiana University. For my dissertation, I am interested in studying the role of clerkship and course directors in academic medical centers. Because faculty members who are academic directors often have multiple responsibilities to see patients, develop and lead educational programs, and keep an active research agenda, they must manage competing priorities and values systems. This study seeks to develop a deeper understanding of how faculty in this role manage these priorities and values.

I am looking to interview clerkship and course directors in academic medical centers no more than two times. The first interview will last approximately 90 minutes, and it will be held a location of your choice, over the phone, or on Skype. It will be entirely confidential. Pseudonyms will be used in place of your name in the final report, and the report will be written in such a way that your identity is masked. All interviews will be tape-recorded and then transcribed to Microsoft Word. The tapes will be destroyed at the completion of the study.

Contact information will be kept strictly confidential and used only by me during the study and will be destroyed afterward. At a later date, I will schedule another interview with you to discuss the themes I've found and give you a chance to share your thoughts.

Your participation is entirely voluntary. You may remove yourself from the study at any time.

The supervising faculty member for this research is Dr. Thomas Nelson Laird, and he can be reached at.

If you are interested in participating, please contact me by replying to this e-mail or phoning me at the number below. I look forward to hearing from you.

Sincerely,
Krista Hoffmann-Longtin

Appendix C: Study Information Sheet

IRB STUDY #1301010448

INDIANA UNIVERSITY STUDY INFORMATION SHEET FOR

By Chance or By Design:
The Organizational Identification of Academic Directors
in Academic Medical Centers in the U.S.

You are invited to participate in a research study of the relationship between clerkship and course directors (academic directors) and academic medical centers in the U.S. You were selected as a possible participant because you are a faculty member who serves in one of these roles. We ask that you read this form and ask any questions you may have before agreeing to be in the study. The study is being conducted by Krista Hoffmann-Longtin, Doctoral Candidate at the Indiana University School of Education.

STUDY INFORMATION
Because faculty members who are academic directors often have multiple responsibilities to see patients, develop and lead educational programs, and keep an active research agenda, they must manage competing priorities and values systems. This study seeks to develop a deeper understanding of how faculty in this role manage these priorities and values.

PROCEDURES FOR THE STUDY
If you agree to be in the study, you will participate in no more than two, 90-minute interviews in person, over the phone or via Skype. The interview will include questions about (1) how you came into your role, (2) how you make sense of your role and values in relationship to those of your university, and (3) how the organization of your university and hospital system might shape your values. Approximately 6-15 people will be involved in this study. The interviews will be audio taped and transcribed.

BENEFITS
This research will advance the body of knowledge of faculty development in academic medical centers.

RISKS
During the interview, you may feel uncomfortable answering the questions. You are welcome to decline to answer any question and you can withdraw from participating in the study at any time.

CONFIDENTIALITY
Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published. A pseudonym will be assigned to each participant, and all interview data will only be published in aggregate. Tapes and transcriptions will be destroyed at the end of the study, no later than June, 2014.

COMPENSATION
You will not receive payment for taking part in this study.

VOLUNTARY NATURE OF STUDY

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty. If you withdraw from the study your individual data will be returned to you or destroyed.

CONTACTS FOR QUESTIONS OR PROBLEMS
For questions about the study, contact the researcher Krista Hoffmann-Longtin at klongtin@iu.edu.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

Information Sheet Date: 3-15-13

Curriculum Vitae

KRISTA HOFFMANN-LONGTIN
klongtin@iu.edu

SUMMARY

* Over twelve years of successful program administration and teaching experience in higher education.
* Developed and implemented evidence-based curricula, faculty development programs, and instructional materials in formal and informal learning environments
* Skilled in the facilitation of mutually beneficial partnerships among university departments and community organizations.

EDUCATION

PhD, Higher Education Administration *December, 2014*
Minor: Communication Studies
Indiana University, Indianapolis, IN

Dissertation: *By chance or by design: The organizational identification of academic directors in U.S. academic medical centers* (Thomas F. Nelson-Laird, Advisor)

MA, Communication *May, 2002*
Minor: Women's Studies
Purdue University Calumet, Hammond, IN

BA, Telecommunications *December, 1998*
Minors: English and Creative Writing
Ball State University, Muncie, IN

EXPERIENCE

Indiana University (Indianapolis campus, IUPUI) 2002-present

Director of Programs and Evaluation (Non-Tenure Faculty Appointment) 2010-present
Indiana University School of Medicine
Office of Faculty Affairs and Professional Development

* Direct faculty development programming for over 1,500 medical school faculty at nine campuses throughout the state, including over 100 workshops per year
* Collaborate with department chairs, division directors, center directors, and the CME office to tailor programming to meet the needs of key faculty groups
* Co-authored the institutional application for the ACE/Alfred P. Sloan Foundation award for Faculty Career Flexibility. One of only five medical schools in the U.S. to receive this award
* Co-lead a faculty development curriculum to recruit and train master educators to implement an AMA-funded teaching EMR.

* Develop and facilitate program evaluation plans for faculty development, diversity affairs, and academic departments
* Manage the publication of school-wide reports, including Department Annual Reports, the State of the Faculty Report and the Faculty Vitality Survey©
* Oversee the development of innovative online faculty development offerings, including an online peer review of teaching form, and database of faculty engagement activities
* Direct organizational development research efforts including appreciative inquiry focus groups, department chair 360° evaluation reports, and vitality studies
* Spearheaded the process of extending the tenure clock for faculty in the school of medicine, including developing policy language and marketing the referendum to receive 2/3 of the faculty's approval
* Worked with a team of colleagues to develop a nationally-recognized, competency-based approach to department chair recruiting, development, and feedback
* Supervise a staff of five (three FTE, two graduate assistants, and an intern)

Associate Faculty *2006-present*
Departments of Communication Studies & Women's Studies
Indiana University School of Liberal Arts at IUPUI

Courses taught:
* Human Communication and the Internet (Capstone, online)
* History of Television (Cross-listed with Department of History)
* Introduction to Interpersonal Communication (online and face-to-face)
* Introduction to Women's Studies

Associate Director (Non-Tenure Faculty Appointment)
Solution Center, Office of University Outreach and Engagement *2006-2010*
Indiana University Purdue University Indianapolis (IUPUI)
* Facilitated partnerships between university faculty and over 300 businesses and community organizations
* Advised faculty and community partners in the creation and implementation of experiential learning curricula and programs such as internships, class projects, capstones, and community-based research projects
* Developed a comprehensive assessment plan for program impact and campus internship programs to produce an annual report and impact study
* Participated in writing and administering a $1.8 million Lilly Endowment grant for supporting experiential learning
* Created a self-sustaining governance structure and led strategic planning of a campus-wide committee on career and internship policy and practice
* Negotiated and implemented a $20,000 interdisciplinary technology contract among 11 academic units

Acting Director
University College Career and Employment Services *2007-2009*
Indiana University Purdue University Indianapolis (IUPUI)

* Supervised a staff of 7 full-time and 3 student employees/interns
* Provided leadership to programs in student employment, federal work-study, career fairs, experiential learning, and student/employer development program
* Administered budgets and grants

Lecturer (with special appointments below) *2002-2006*
Indiana University Purdue University Indianapolis (IUPUI)
Departments of Communication Studies & Women's Studies

Courses taught:

* Human Communication & the Internet
* History of Television
* Introduction to Communication Studies
* Introduction to Interpersonal Communication (online and F2F)
* Introduction to Public Speaking
* Introduction to Women's Studies
* Mass Media & Contemporary Society
* Media Literacy

Civic Engagement Coordinator *2005-2006*

* Received a $44,000 grant with a team of four faculty members to infuse service learning horizontally and vertically into the curriculum
* Coordinated departmental engagement initiatives, including assessment and reporting
* Established a Community Partners Advisory Board of non-profit organizations
* Assisted individual faculty members in designing and implementing civic engagement and service learning activities
* Supervised graduate assistant and service learning student assistant

Basic Course Director *2004-2005*

* Developed curriculum for and coordinated two introductory courses: Introduction to Interpersonal Communication and Media and Society
* Managed a team of nearly 20 full and part-time faculty, conducting instructor observations, addressing course-related concerns of faculty and students, and planning biyearly development sessions

Lead Academic Advisor/Internship Coordinator *2003-2004*

* Worked with all faculty advisors to disseminate school and departmental advising information to over 300 majors
* Created and maintained policies for departmental internship program
* Coordinated with school officials to determine transfer credit equivalencies
* Developed departmental marketing and recruitment materials including the department website and campus events

Purdue University Calumet (Hammond, IN) **2000- 2002**

Graduate Assistant *2000-2002*
Office of Career and Leadership Development

* Expanded and improved orientation on campus including implementation of and training for a peer-mentoring program

Graduate Teaching Assistant *2000-2002*
Department of Communication and Creative Arts

* Taught Introduction to Communication Studies
* Selected by the course director to develop online programs and resources for faculty
* Chosen as the first graduate student in the department to participate in a graduate teaching assistant exchange program with Purdue University West Lafayette

OTHER PROFESSIONAL EXPERIENCE

Account Manager
The Weather Channel, Chicago, IL *1998-2000*

* Worked on client teams with Regional Managers to sell advertising and represent The Weather Channel to ad agencies, sales clients, and the public
* Created sales presentations which maximized brand identity of both The Weather Channel and its clients, including Penske Auto Services, Sara Lee, and Wal-Mart

Research Assistant
Indiana Public Radio, WBST-FM, Muncie, IN *1997-1998*

* Worked with writers and producers to develop story ideas, research and book talent for the show, and locate archival audio footage

ADDITIONAL PROFESSIONAL EDUCATION

Certificate, Higher Education Resource Services (HERS) Institute *July, 2009*
Bryn Mawr College, Bryn Mawr, PA

* Month-long residential training opportunity which prepares participants to work with issues currently facing higher education. Competitive selection process on the IUPUI campus.

PEER-REVIEWED PUBLICATIONS

Hoffmann-Longtin, K., Palmer, M.M., Walvoord, E.C., & Dankoski, M.E. (2014). Collaborating with faculty for effective communication strategies: An untapped resource. *To Improve the Academy, 34.* In press.

Palmer, M.M., **Hoffmann-Longtin, K.,** Walvoord, E.C., & Dankoski, M.E. (2014). Stepping Stones: A faculty development program to inspire future women leaders. *International Journal of Academic Development.* Under review.

Palmer, M.M., **Hoffmann-Longtin, K.,** Walvoord, E.C., & Dankoski, M.E. (2014). A competency-based approach to department chair recruitment, development, and assessment. *Academic Medicine.* In press.

Palmer, M.M., Shaker, G. G., & **Hoffmann-Longtin, K**. Despite faculty skepticism: Success of a graduate-level seminar in a hybrid course environment. *College Teaching*. In press.

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Palmer, M.M., **Hoffmann-Longtin, K**., Ribera, A.K., Ribera, T., & Laird, T.N. (2012). Enhancing vitality in academic medicine: Faculty development and productivity. *To Improve the Academy, 32*.

Dankoski, M., Palmer, M., Banks, J., Brutkiewicz, R., Walvoord, E., **Hoffmann-Longtin, K**., Bogdewic, S., et al. (2012). Academic writing: Supporting faculty in a critical competency for success. *The Journal of Faculty Development*, *26*(2), 47-54. Retrieved from http://newforums.metapress.com/content/T3653831883N0686

BOOK CHAPTERS

Welch, J., **Hoffmann-Longtin, K**., Dell, M.C., Eynon, J., Rusyniak, D., & Dankoski, M.E. (2014). Building a culture of mentoring via a faculty mentoring portal. In G. Wright (Ed.), *The mentoring continuum: From graduate school through tenure*. New York, NY: The Graduate School Press of Syracuse University. In Press.

Dankoski, M., Palmer, M., Banks, J., Brutkiewicz, R., Walvoord, E., **Hoffmann-Longtin, K**., Bogdewic, S., et al. (2012). Academic writing: Supporting faculty in a critical competency for success. In E. Neal (Ed.), *Academic writing: Individual and collaborative strategies for success* (pp. 119-131). Stillwater, OK: New Forums Press.

Longtin, K., & Thedwall, K. (2005). Making connections using the discussion forum. In L. J. Goodnight & S. P. Wallace (Eds.), *The basic communication course online: Scholarship and application* (pp. 61-67). Dubuque: IA: Kendall-Hunt.

OTHER PROFESSIONAL PUBLICATIONS

Palmer, M.M., **Hoffmann-Longtin, K**., & Dankoski, M.E. (2012, July). Aligning executive recruitment practices around core leadership competencies. *GWIMS Watch: The Quarterly Newsletter of the Association of American Medical Colleges Group on Women in Medicine and Science*.
Available: https://www.aamc.org/members/gwims/recommended_reading/139800/gwims_watch.html

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Longtin, K. & the IUPUI Department of Communication Studies (Eds.). (2006). *Introduction to interpersonal communication: A supplemental reader.* Plymouth, MI: Hayden McNeil.

EDUCATIONAL MULTIMEDIA PRODUCTIONS

Palmer, M.M., **Hoffmann-Longtin, K**., Eynon, J.S., & Chism, N.V.N. (2011). *Online peer review form builder and module.* Developed for the Indiana University School of Medicine Academy of Teaching Scholars.
Available: http://faculty.medicine.iu.edu/peerReview/

Sygiel, L., et al. (2009). *The Power of a Question* [online curriculum]. Indianapolis, IN: Y-Press and the Indianapolis Star.
Available: http://www.ypress.org/special_project/power_of_the_question

Longtin, K. (Producer, Writer, Director, & Editor). (2002). *Gloria Steinem, the Spice Girls, and me: Defining the Third Wave of feminism* [video]. Hammond, IN: Purdue University Calumet.

Pea, B. (Producer & Director), & **Longtin, K**. (Writer & Editor). (1998). *Take nothing but pictures: A journey through Indiana's caves* [video]. Muncie, IN: WIPB. (Available through the National Speleological Society, www.caves.org).

Longtin, K. (Producer, Writer & Director). (1997). *Academic expectations at Ball State University* [video]. (Available at Ball State University Office of Admissions, Administration Building, Muncie, IN 47306).

GRANTS

Hess, J. (P.I.), Bogdewic, S. P., (co-PI), Dankoski, M.E., Palmer, M.M., **Hoffmann-Longtin, K**., (2012). American Council on Education / Alfred P. Sloan Award for Faculty Career Flexibility. $250,000

Palmer, M.M. (co-P.I.), Dankoski, M.E. (co-PI), **Hoffmann-Longtin, K**., Bogdewic, S. P. (2011). Macy Foundation Presidential Grant, Advancing Faculty Vitality in the Health Professions, $35,000.

Palmer, M.M. (PI), Dankoski, M.E., **Hoffmann-Longtin, K**.., Bogdewic, S. P. (2010-2011). *Expanding the concept of faculty vitality*, Professional and Organizational Development Network Research Grant, $3,000.

Baldwin, D., & **Longtin, K**. (2008*). Multidisciplinary undergraduate research grant for the American Legion marketing project.* IUPUI Center for Research and Learning. Amount: $7,000.

Longtin, K. (2006). *Jump start web course development grant*. IUPUI Office for Professional Development. Amount: $5,000 plus in-kind web design services.

Goering, E., **Longtin, K**., Sandwina, R., & Sheeler, K. (2005, renewed 2006). *Commitment to excellence engaged department grant.* IUPUI Office of Service and Learning. Amount: $44,000.

Longtin, K. (2005). *Learning environments grant*. IUPUI Office for Professional Development. Amount: $10,000.

Longtin, K. (2003). *Lecturer development grant*. IUPUI Office for Professional Development. Amount: $3,000

Longtin, K., & Thedwall, K. (2003). *Gateway development grant*. IUPUI Office for Professional Development, Gateway Course Committee. Amount: $10,000.

Longtin, K. (2003). *Lecturer development grant*. IUPUI Office for Professional Development. Amount: $3,000

PEER-REVIEWED PRESENTATIONS

Anderson, K., Feldner, S., **Hoffmann-Longtin, K**., Sheeler, K.H., Procopio, C.H., & Tate, H. (2013, November). *Conscious connections: Using your communication savvy to advance women's interests.* Competitively selected panel presentation at the National Communication Association Conference in Washington, DC.

Palmer, M.M., Dankoski, M.E., & **Hoffmann-Longtin, K**. (2013, November). *Public display of reflection: Stepping stones of women in leadership*. Competitively selected presentation at the Professional and Organizational Development Network in Higher Education conference in Pittsburgh, PA.

Hoffmann-Longtin, K., & Eynon, J. (2013, August). *Collaborating with faculty for effective communication strategies: An untapped resource*. Competitively selected presentation at the AAMC Group on Faculty Affairs Conference in Minneapolis, MN.

Hoffmann-Longtin, K., Congdon, J.L., Cangiarella, J., Palmer, M.M., Dankoski, M.E., Short, J.B., Jacob, D., and Thorndyke, L.E. (2013, August). *Effective department and chair reviews: New models and promising practices*. Competitively selected panel presentation at the AAMC Group on Faculty Affairs Conference in Minneapolis, MN.

Anderson, K., Feldner, S., **Hoffmann-Longtin, K**., Sheeler, K.H., Procopio, C.H., & Tate, H. (2012, November). *Job-seeking and hiring as participation in the academic COMMunity: Insights from women who hire.* Competitively selected panel presentation at the National Communication Association Conference in Orlando, FL.

Hoffmann-Longtin, K., & Johnson, C. (2012, October). *Who is your public? Using communication strategies to engage faculty.* Competitively selected presentation at the Professional and Organizational Development Network in Higher Education conference in Seattle, WA.

Palmer, M.M., Dankoski, M.E., **Hoffmann-Longtin, K**., & Nelson-Laird, T., Ribera, A., & Ribera, T. (2012, October). *Variations in vitality across diverse faculty groups: A multi-institutional, multi-disciplinary study of faculty vitality in the health professions.* Competitively selected presentation at the Professional and Organizational Development Network in Higher Education conference in Seattle, WA.

Palmer, M.M., Dankoski, M.E., **Hoffmann-Longtin, K**., & Ribera, T. (2012, August). *Variations in vitality across diverse faculty groups: A multi-institutional, multi-disciplinary study of faculty vitality in the health professions.* Competitively selected presentation at the AAMC Group on Faculty Affairs Conference in Indianapolis, IN.

Walvoord, E.C., Dankoski, M.E., **Hoffmann-Longtin, K.**, & Palmer, M.M. (2012, August). *Professional coaching: Unorthodox mentoring in the demanding world of academic medicine.* Competitively selected presentation at the AAMC Group on Faculty Affairs Conference in Indianapolis, IN.

Anderson, K., Feldner, S., **Hoffmann-Longtin, K**., Sheeler, K.H., Procopio, C.H., & Tate, H. (2011, November). *Do You Want to Be Right or Do You Want to be Effective? Using Your voice to deal with difficult people in the academy.* Competitively selected panel presentation at the National Communication Association Conference in New Orleans, LA.

Benson, N.H., Bogdewic, S.P., Geist, L.J., Nelson, K.G., Shorey, J.M., Smith, P.O., & **Hoffmann-Longtin, K**. (2011, August). *Someone is rooting for you: Using appreciative inquiry to understand the future of faculty affairs*. Competitively selected presentation at the AAMC Group on Faculty Affairs Conference in Seattle, WA.

Hoffmann-Longtin, K. (2010, November). *Clearing paths and building bridges*. Competitively selected paper presentation at the National Communication Association Conference in San Francisco, CA.

Dankoski, M.E., & **Hoffmann-Longtin, K**. (2010, September). Top-down and bottom-up: Using data to drive changes in faculty career flexibility. Presentation at the Invitational Conference *Advancing an Agenda for Excellence: Creating Flexibility in Faculty Careers in Academic Medicine* American Council on Education, University of Illinois College of Medicine, and Alfred P. Sloan Foundation, Chicago IL.

Anderson, K., Feldner, S., **Hoffmann-Longtin, K**., Sheeler, K.H., Procopio, C.H., & Tate, H. (2009, November). *The changing academic job market: Tips for women job seekers.* Competitively selected panel presentation at the National Communication Association Conference in Chicago, IL.

Hoffmann-Longtin, K. (2008, November). *Unconventional mindsets? Millennials as students, colleagues and citizens.* Competitively selected panel presentation at the National Communication Association Conference in San Diego, CA.

Hoffmann-Longtin, K. (2007, November). *Re-envisioning service in a contract position*. Competitively selected panel presentation at the National Communication Association Conference in Chicago, IL.

Hoffmann-Longtin, K. (2007, April). *Engaging responsibility: Assessing our civic engagement efforts*. Competitively selected panel presentation at the Central States Communication Association Conference in Minneapolis, MN.

Hoffmann-Longtin, K. (2007, April). *Social responsibility in the global classroom: An exploration of issues in teaching abroad.* Competitively selected panel presentation at the Central States Communication Association Conference in Minneapolis, MN.

Longtin, K. (2006, November). *Creating a site for interpersonal connection and action in the online basic course: Using free media and discussion forums.* Competitively selected panel presentation at the National Communication Association Conference in San Antonio, TX.

Longtin, K. (2005, November). *Creating a healthy curriculum: The vertical and horizontal integration of civic engagement into the communication curriculum.* Competitively selected panel presentation at the National Communication Association Conference in Boston, MA.

Longtin, K. (2005, November). *Feminism at the crossroads: The intersection of Womanism and 3rd Wave Feminism.* Competitively selected paper presentation at the National Communication Association Conference in Boston, MA.

Longtin, K. (2005, November). *Negotiating the tenure track: Strategies that acknowledge gender, institutional affiliation, and family circumstance.* Competitively selected panel presentation at the National Communication Association Conference in Boston, MA.

Longtin, K. (2004, November). *Public speaking and classroom assessment.* Competitively selected panel presentation at the National Communication Association Conference in Chicago, IL.

Longtin, K., & Thedwall, K. (2004, October). *Voicing Intersections: An Ethnography of Teachers' and Students' Intercultural Experiences in Russia.* Competitively selected paper presentation at the International Scholarship of Teaching and Learning Conference in Bloomington, IN.

Longtin, K. (2004, May). *What's New: What's new?: Creating a training and professional development program for basic course faculty*. Competitively selected presentation at the Russian Communication Association Conference in Rostov-on-Don, Russia.

Longtin, K. (2004, April). *Gloria Steinem, the Spice Girls and me: Defining the Third Wave of feminism.* Competitively selected paper presentation at the Central States Communication Association Conference in Cleveland, OH.

Bonewits, S., & **Longtin, K**. (2003, November). *10 things I hate about the 'F' word: Conflicting gender messages in 'Legally Blonde' and '10 Things I Hate About You.'* Competitively selected paper presentation at the National Communication Association Conference in Miami, FL.

Longtin, K. (2003, November). *Feminist pedagogy, reaching out to the community and reaching in to the classroom: A panel discussion on practical feminist classroom strategies.* Competitively selected presentation at the National Communication Association Conference in Miami, FL.

Longtin, K. (2003, October). *Gloria Steinem, the Spice Girls and me: Defining the Third Wave of feminism.* Competitively selected presentation at the Organization for the Study of Communication, Language, and Gender Conference in Cincinnati, OH.

PEER-REVIEWED POSTER PRESENTATIONS

Dankoski, M.E., **Hoffmann-Longtin, K**., **Walvoord, E.C.,** & Palmer, M.M. (2013, August). *Stepping stones: Nine lessons from women in leaders in academic medicine.* Presented at the AAMC Group on Women in Medicine and Science poster session in Philadelphia, PA.

Hoffmann-Longtin, K., Johnson, C., Dell, M., & Eynon, J. (2012, August). *Who Is Your Public? Using Communication Strategies to Engage Faculty in Development Opportunities*. Presented at the AAMC Group on Faculty Affairs Conference in Indianapolis, IN.

Brutkiewicz, R.R., Black, M.V., Cushion, M., Lakoski, J., Milner, R., Patel, K., Weber-Main, A.M., Vrana, K., Vrana, S., & **Hoffmann-Longtin, K.** (2012). *Senior K Award: A Tool to Assist Senior Research Faculty Reinvent themselves to Maintain Vitality and their Contributions to their Institution.* Presented at the AAMC Group on Faculty Affairs Conference in Indianapolis, IN.

Dankoski, M.E., Bogdewic, S.P., Cordes, S.R., **Hoffmann-Longtin, K.**, & Palmer, M.M. (2012). *Advancing Women in Medicine and Science at Indiana University School of Medicine: Vision, Methods, and Outcomes.* Presented at the AAMC Group on Faculty Affairs Conference in Indianapolis, IN.

Walvoord, E.C., Palmer, M.M., Dankoski, M.D., Brutkiewicz, R.R., **Hoffmann-Longtin, K**., & Bogdewic, S.P. (2011, August). *Does participation in a junior faculty development program result in improved career satisfaction?* Presented at the Association of American Medical Colleges Group on Faculty Affairs Annual Conference, Seattle, WA.

Palmer, M.M., **Hoffmann-Longtin, K**., Eynon, J.S., & Chism, N.V.N. (2011, October). Online peer review form builder and module. Presented at the Professional and Organizational Development Network Conference in Atlanta, GA.

Dankoski, M.E., Cordes, S.L., Palmer, M.M., **Hoffmann-Longtin, K**., & Bogdewic, S.P. (2011, November). *Advancing Women in Women and Science at Indiana University School of*

Medicine: Vision, Methods, and Outcomes. Presented at the Association of American Medical Colleges Group on Women in Medicine and Science Annual Poster Session, Denver, CO.

INVITED PRESENTATIONS

Hoffmann-Longtin, K. (2012, October). *Information age expectations: Using technology to improve relationships among dentists, colleagues, and patients.* Presented to the Great Lakes Orthodontists Association annual conference in Indianapolis, IN.

Hoffmann-Longtin, K. & Cochrane, J. (2011, February). *Your brain on computers: Using media ethically and effectively*. Presented to the IU Alumni Association annual conference in Indianapolis, IN.

Hoffmann-Longtin, K. (2011, October). *Strategic planning*. Presented to the Indy Pride Board of Directors. Indianapolis, IN.

Hoffmann-Longtin, K. (2010, November). *Props: Policies and personas for women in the academy*. Invited presentation at the National Communication Association pre-conference on women in the academy in San Francisco, CA.

Hoffmann-Longtin, K. (2009, March). I was a teenage feminist: Film screening and discussion. Presented for the IUPUI Office for Women.

Longtin, K. (2006, July). Interpersonal communication in organizations. Presented to the Alzheimer's Association of Indiana. Indianapolis, IN.

Longtin, K., & Sheeler, K. (2006, May). Talking 9 to 5: Additional perspectives on Tannen's work. Presented for the IUPUI Office for Women. Lecture and discussion following audience viewing of Deborah Tannen's film *Talking 9 to 5*.

Longtin, K. (2004, October). *Corporate, media, and political views of and from women: A research colloquium.* Presented with Kristy Sheeler and Kim White-Mills for the IUPUI Department of Communication Studies.

Longtin, K. (2004, September). *How to run a meeting without it running away*. Presented to the IUPUI Student Organization Advisory Board. Indianapolis, IN.

Longtin, K. (2003, March). *Gloria Steinem, the Spice Girls and me: Defining the Third Wave of feminism*. Presented at St. Mary's College Women's History Month.

Longtin, K. (2003, March). *Gloria Steinem, the Spice Girls and me: Defining the Third Wave of feminism*. Presented at Indiana State University Women's History Month.

Longtin, K. (2003, March). *Gloria Steinem, the Spice Girls and me: Defining the Third Wave of feminism.* Keynote presentation for Purdue University Calumet Women's History Month.

SELECTED HONORS AND AWARDS

POD Innovation Award Finalist, Professional and Organizational Development Network, 2013
POD Innovation Award Finalist, Professional and Organizational Development Network, 2010
IUPUI Outstanding Female Faculty Member Nominee, 2006
Advisor of the Year Nominee by the IUPUI Undergraduate Student Government, 2005
Outstanding Mentor in the IU School of Liberal Arts, 2002-2006
The Communicator Award of Distinction for Film and Video, 2003
Outstanding Teaching Assistant Award, Purdue Calumet Department of Communication, 2002
Outstanding Student Award, Purdue Calumet Alumni Association, 2001
Merit in Graduate Research, Purdue Calumet Department of Communication, 2000

SELECTED UNIVERSITY SERVICE

Education Team Leader
IU School of Medicine Curricular Reform Task Force 2011-2012

Member, Ex-Officio
IU School of Medicine Faculty Steering Committee 2010-2012

Member
IUPUI E.C. Moore Symposium on Excellence in Teaching 2011-present
IUPUI Office for Women Advisory Board 2008-present
Fundraising Event Sub-Committee Member 2008-2009
IU Gender Incidents Team 2009-2011
IUPUI Central Indiana Talent Alliance Working Group Member 2009
IUPUI Program Review and Assessment Committee 2006-2011
IUPUI Gateway to Graduation Advisory Committee 2006-2011
IUPUI School of Liberal Arts Strategic Planning Committee 2005
IUPUI School of Liberal Arts Committee on Lecturer Affairs 2004-2005

Workshop Facilitator
Lead IUPUI 2006-2011
IUPUI GLBT Day of Silence 2005

SELECTED PROFESSIONAL SERVICE

Conference Proposal Reviewer

Professional and Organizational Development Network (POD)	2010-present
National Communication Association Women Studies Division	2008-present

Board President/Chair

Indiana Council for Internships and Cooperative Education	2009-2011

Secretary

National Communication Association Women Studies Division	2004-2008

Conference Planner

Central States Communication Assoc. Women Studies Division	2003-2004
Indiana Council for Internships and Cooperative Education	2007-2011

SELECTED COMMUNITY SERVICE

Board President/Chair

Ball State University Telecommunications Alumni Board	2010-2014
WFYI Public Media Young Professionals Group	2011-2013
Indianapolis International Film Festival	2004-2008

Board Member

Ball State University Telecommunications Alumni Board	2014-present
WFYI Public Media Young Professionals Group	2009-2011
Handi-Capable Hands, Inc.	2008-present
Indiana Economic Development Commission Film Indiana Initiative	2008-present
Indiana Council for Internships and Cooperative Education	2008-2009
Indianapolis International Film Festival	2003-2004